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David J. Sanchez, Jr., Ph.D.
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HEALTH COMMISSION
CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Sandy Ouye Mori
Executive Secretary

TEL: (415) 554-2666

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**MINUTES
OF THE
JOINT CONFERENCE MEETING
FOR
SAN FRANCISCO GENERAL HOSPITAL**

DOCUMENTS DEPT.

MAR - 2 2000

**SAN FRANCISCO
PUBLIC LIBRARY**

Tuesday, February 22, 2000
3:00 p.m.

1001 Potrero Avenue, Room #2A6
San Francisco, CA 94110

1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Commissioner Harrison Parker at 3:25 p.m., until Commissioner Edward A. Chow arrived at 3:35 p.m.

Present: Commissioner Edward A. Chow, M.D.
Commissioner Harrison Parker, Sr., D.D.S.

2) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION

None.

Commissioners went into Closed Session at 3:28 p.m.

3) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

Action Taken: The minutes for December 14, 1999 were approved.

**CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE AND
QUALITY ASSURANCE MATTERS**

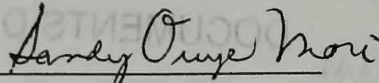
Commissioners came out of Closed Session at 4:39 p.m.

4) **RECONVENE IN OPEN SESSION**

**VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS
HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE
CODE SECTION 67.12(a) (ACTION ITEM)**

Action Taken: The Commissioners voted not to disclose any discussions
held in Closed Session.

The meeting was adjourned at 4:40 P.M.



Sandy Ouye Mori
Executive Secretary to
the Health Commission

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AGENDA

**JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING**

Tuesday, March 14, 2000

3:30 - 6:00 p.m.

1001 Potrero Street, Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

MAR - 7 2000

SAN FRANCISCO
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Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.

- 1) **CALL TO ORDER**
- 2) **FOR APPROVAL: MINUTES OF FEBRUARY 22, 2000**
- 3) **FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE**
(May include activities and operations at SFGH)
(Gene O'Connell, SFGH Executive Administrator)
- 4) **FOR DISCUSSION: PATIENT CARE REPORT**
(May include nursing and patient care issues)
(Delores Gomez, RN, MS, Chief Nursing Officer, SFGH)
**Report*
- 5) **FOR DISCUSSION: FINANCE REPORT - STATEMENT OF REVENUES AND EXPENDITURES**
(Ken Jensen, Chief Financial Officer, CHN)
**Report*

- 6) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**
- 7) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

**FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT,
QUALITY OF CARE, QUALITY ASSURANCE,
AND CREDENTIALING MATTERS**

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director CHN-QUM
Hiroshi Tokubo, Director of QM

- 8) **RECONVENE IN OPEN SESSION**

**VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL
DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO
ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM)**

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Sunshine Ordinance Task Force
Rachel Arnstine O'Hara, Clerk
City Hall, Room 362
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4683

Telephone: (415) 554-6171
Fax: (415) 554-6177
E-mail: Rachel_ArnstineO'Hara@ci.sf.ca.us

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MINUTES

JOINT CONFERENCE MEETING FOR SAN FRANCISCO GENERAL HOSPITAL

Tuesday, March 14, 2000
3:30 p.m.
1001 Potrero Avenue, Room #2A6
San Francisco, CA 94110

1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Chairperson Commissioner Lee Ann Monfredini at 3:34 p.m..

Present: Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.

1) CALL TO ORDER

2) APPROVAL OF MINUTES OF FEBRUARY 22, 2000

Action Taken: The Commissioners unanimously adopted the minutes of February 22, 2000.

3) HOSPITAL HEALTHCARE UPDATE (Gene O'Connell, SFGH Executive Administrator)

RADIOLOGY DEPARTMENT UPDATE

Radiology CT/MRI Wait Times

The current wait times for outpatient CT and MRI are 17-18 and 30-38 days respectively. Emergency CTs and MRIs are always given highest priority and bump all other cases. A recent

study of Emergency Department CT scans demonstrated that the average time from computerized request (Order Entry) to completion of the study was one hour, with a range of 0 minutes to 7 hours, 50 minutes. This longest case was repeatedly bumped for other trauma cases, and a screening sonogram was completed to ensure the patient's safety during the long wait. Although the one-hour average is acceptable, the study will be repeated in September 2000, with the expectation that the longer wait times will be decreased. A Policy and Procedure was recently adopted to clearly define under what circumstances the second scanner will be opened during off-hours. It also defines the number and type of staff required to accomplish this.

Overall, radiology volume has increased slightly, from 143,000 exams in 97/98 to 150,000 exams in 1998/99. The most significant trend has been the increasing utilization of CT, MRI, ultrasound, mammography and interventional procedures. These are all personnel intensive. While the Department would like to establish a seven-day standard for first available CT/MRI appointment, the wait times have slowly crept up with increasing demand for the services and a static labor pool. The Department has not maximized its CT, MRI, mammogram and ultrasound capacity in the evening and weekend hours due to staffing levels, but could reduce wait times if additional funding could be identified.

Radiology Transcription

Last summer, the Radiology Department, working with the IS Department, evaluated the SMS Radiology Information System as a potential system for conversion to be Y2K compliant. Numerous systems and interface problems, as well as training issues, plagued the conversion in November and December of 1999. While the Y2K issues were minimal, the version installed was found to have a transcription program that was only 60% as efficient as the previous transcription system. Dictation of results has not been a problem. This has created a 40% untranscribed rate of daily dictations from mid-November to date.

This issue has been reviewed with Quality and Risk Management, and steps are underway to rectify the problem. In addition to an outside consultant engaged to evaluate the professional fee billing system, an SMS consultant group has been convened to perform a diagnostic review and assist the Department in resolving the problems.

The Department has implemented the following:

- Engaged additional external transcriptionists and determined a procedure to ensure entry of all results into LCR
- Mandated that radiologists promptly verbally communicate abnormal results found
- Ensured abnormal results are flagged/prioritized for immediate transcription
- Prioritized mammogram and ultrasound results for immediate transcription
- Ensured that Radiology staff respond promptly to calls from care providers and make all efforts to locate films and have them read promptly over the phone by Radiologists
- Begun exploring a variety of Voice Recognition Systems to substitute for the SMS dictation and transcription program

ANNOUNCEMENTS

Personnel Changes

Over the past month, many SFGH staff has assumed new positions with the Department of Public Health.

- Phyllis Harding, former Associate Administrator for Psychiatry and Substance Abuse, has recently assumed the position of Director of Substance Abuse Services within the Population, Health and Prevention branch. Chris Wachsmuth's responsibilities as an

Associate Administrator have been expanded to now also include Psychiatric Emergency Services (PES). Leslie Holpit, who is currently the Director of Psychiatric Nursing, will now also be responsible for acute inpatient and behavioral health services.

- Robert Christmas, former Associate Administrator of Licensure and Accreditation Services, has assumed the new role of Chief Operating Officer at Laguna Honda Hospital. The responsibility of coordinating JCAHO activities will now be the responsibility of Hiroshi Tokubo, Director of Quality Management and his department.
- Greg Johnson, former Director of Employee Services, has assumed the new position as Executive Assistant to the Laguna Honda Hospital Executive Administrator. LaFrancine Tate will now assume his responsibilities.
- Anne Hughes, clinical nurse specialist for HIV Disease/Oncology, will assume the new position of clinical nurse specialist for palliative care. A clinical nurse specialist for the Medical –Surgical units will be hired in the future.

New Assignments

- Angela Carmen, whose most recent appointment has been Assistant Administrator in Facilities Management, in charge of Parking, Transportation, and Property Management, will now also assume the responsibility for the departments of Materials Management, Patient Escorts, and Linen Services.

Department of Health Services Report

In May 1999, San Francisco General Hospital Medical Center participated in the Consolidated Accreditation and Licensure Survey (CALs), which included the surveying organizations of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the California Medical Association (CMA), and the California State Department of Health Services (DHS). Shortly after the survey, SFGH received both the JCAHO and CMA report. Just last week, SFGH finally received the report from DHS.

Since it has been 10 months since the survey, staff is currently in the process of clarifying some of the issues contained in the report with DHS. All issues have been assigned to appropriate administrators. Quality Management will be coordinating the response back to DHS.

Soft Tissue Infection Clinic

Work is continuing on “jump-starting” the Soft Tissue Infection program. Efforts to release the first Nurse Practitioner/Physician’s Assistant requisition are underway. The Wound Care Standards Subcommittee of the Management of Abscess/IVDU Task Force has met three times and has made significant progress in identifying the clinical issues. Discussion with surgical, nursing, and medical social services staff to create the Hospital-based program have been initiated. Implementation of the physical facility changes will begin in April. The next meeting of the Abscess/IVDU Task Force will be on April 21, 2000, at which time updates will be shared with all members.

Commissioner Chow expressed concern about the wait times in radiology.

Commissioner Monfredini would like to relook at this issue in September through a Quality Management Report.

4) PATIENT CARE REPORT

(Delores Gomez, RN, MS, Chief Nursing Officer, SFGH)

Ms. Gomez submitted the Patient Care Report, (Attachment A).

- 5) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Ken Jensen, Chief Financial Officer, CHN)

Ms. Jensen submitted a Revenue and Expense Summary for January 2000, (Attachment B).

- 6) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**

None.

- 7) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**

None.

- 8) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

**CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE,
QUALITY ASSURANCE, AND CREDENTIALING MATTERS**

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QUM

Closed session started at 4:40 p.m.
Closed session ended at 5:30 p.m.

- 9) **RECONVENE IN OPEN SESSION**

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a))

Action Taken: The Commissioners voted not to disclose any discussions held in Closed Session.

The meeting was adjourned at 5:32 p.m.

Sandy Ouye Mori
Executive Secretary to
the Health Commission

Attachments (2)

Patient Care Report

San Francisco General Hospital Medical Center

Submitted by: Dolores Gomez, RN, MN,
Chief Nursing Officer

Operating Room Nurse Training Program

As has been reported in previous Joint Conference Committee reports, there is a shortage of RNs throughout the U.S. and California, particularly in the high-tech/specialty areas. The Perioperative nurse shortage has continued to be acute with over 150 vacancies in Northern California. The average age of a nurse working in Perioperative Nursing is in the mid-50's and our own Operating Room (O.R.) is reflective of this as well.

In 1998, Perioperative Management recognized this issue as a major problem for SFGHMC and began meeting with all Bay Area hospitals. With limited in-house resources to train RNs, a training program was developed which included sending selected nurses through the Consortium Education Network O.R. Nursing Training Program. In addition to didactic training, nurses are given hands-on training at other facilities as well as here at SFGHMC. In June of 1999, three in-house RNs were sent through and completed training. Nurse training for the O.R. is extensive. The program itself costs \$4,000 for each candidate in addition to a 6-month training period to complete all training objectives. By the end of December we had three fully trained O.R. nurses capable of running most surgical procedures. The interview process (13 candidates interviewed) was completed for a second program which began on February 7th. Four RNs were selected, two internal employees and two external RNs. By July 2000 we will have a total of seven new skilled RNs in Perioperative Nursing.

Critical Care Nurse Training

Critical Care, Perioperative, and Emergency Nursing are the most difficult to recruit for areas in nursing nationwide, as well as locally. We are once again recruiting candidates for a Critical Care Nurse Training Program targeted to begin April 10th. Last fall we recruited both internally and externally and received only five interested applicants. Only one candidate passed the screening process at that time. We have interviewed eight candidates, of which three were selected to enter the training program in April.

New Med-Surg Nursing Director

Joseph Pendon, RN, MSN accepted the position of Medical-Surgical Nursing Director and began his employment on February 1st. Joseph comes to us from Contra Costa Regional Medical Center where he has functioned in a variety of roles, including New Programs Manager, Special Projects, and Nursing Supervisor. He brings with him 13 years of managerial experience in both community and county facilities.

4A SNF Nurse Manager

Ana Sampera RN, has accepted the reassignment from Utilization Management(UM) to the Nurse Manager position on 4A SNF. Ana has worked in a variety of settings at SFGHMC, most recently in UM as Case Manager for the 4A SNF resident population. In addition, Ana has served as the liaison with Laguna Honda Hospital regarding long term SNF placement.

Emy Revease has been the Acting Nurse Manager on 4A SNF since July 1998. Emy will stay on 4A SNF as MDS Coordinator and will assist with the transition of Ana to her new role. We thank Emy for her commitment and dedication to 4A SNF as acting Nurse Manager over the past 18 months.

Diversion

The Emergency Department recorded 35 episodes of Total Diversion during the month of February, or 24.1 % for the month. The majority of episodes were due to capacity issues within the Emergency Department.

Critical Care recorded six episodes of diversion or 7.9%. Critical Care census began to rise toward the end of December and has remained high through the month of February.

HART Diversion System Implementation

On March 1, SFGHMC joined other City of San Francisco hospitals and the SFFD Communication Center in implementing the new computerized hospital diversion alert system. The new HART (Hospital Ambulance Resource Tracking) system replaces the CHORAL/TRENDS system in providing up to the minute information on the open/divert status of all receiving hospitals in San Francisco. This system was created by the American Medical Response (AMR) ambulance company for use in both San Mateo and San Francisco Counties. SFGHMC will be able to display data on both Counties' systems. The system is internet-based and password protected for security and confidentiality of information. System status data will continue to be reported by the EMS Agency.

Antenatal Testing

Planning for the move of Antenatal Testing from the 6th Floor location to the 5^M Floor Women's Clinic has been underway to better meet the needs of pregnant women. Currently, pregnant women seen in 5M are required to walk up to the 6th floor for testing to be done. Relocating the Antenatal Testing Center to the 5M Clinic provides a "one stop shop" for prenatal care. The anticipated move is scheduled for April.

Conscious Sedation

The Conscious Sedation Task Force chaired by Gayling Gee has been meeting regularly to oversee all areas providing conscious sedation. Its charge is to ensure same standard of care provided, consistent nursing management, and documentation of conscious sedation/care provided as specified in the Hospital Policy and Procedure. A Site Review Tool and Chart Review Audit have been developed. The Task Force has recently been endorsed as an official subcommittee of the Nursing CQI Committee and will be reporting on a regular basis to the Committee.

Title XV Survey

The annual Title XV Survey of Units 7D, 7L, 7B, and the holding cell in Institutional Police took place on January 31st. There were minimal findings/deficiencies noted during the survey, which were quickly corrected and are no longer outstanding.

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AGENDA

**JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING**

Tuesday, April 11, 2000
3:30 - 6:00 p.m.
1001 Potrero Street, Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

APR - 7 2000

Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.

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- 1) CALL TO ORDER
- 2) FOR APPROVAL: MINUTES OF MARCH 14, 2000
- 3) FOR DISCUSSION: PRESENTATION OF A PROJECT ON HIGH UTILIZERS OF ACUTE MEDICAL INPATIENT SERVICES
(Alicia Fernandez, M.D., Director of Inpatient Services, SFGH Dept. of Medicine)
**Report*

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

- 4) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**
- 5) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION
- 6) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF FEBRUARY 22, 2000 AND MARCH 14, 2000

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QUM
Hiroshi Tokubo, Director of QM
Alison Moed, Director of Risk Management

7) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM))

**** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.**

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MINUTES

JOINT CONFERENCE MEETING FOR SAN FRANCISCO GENERAL HOSPITAL

Tuesday, April 11, 2000
3:30 p.m.
1001 Potrero Avenue, Room #2A6
San Francisco, CA 94110

1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Chairperson Commissioner Lee Ann Monfredini at 3:30 p.m..

Present: Commissioner Lee Ann Monfredini, Chairperson
Commissioner Roma P. Guy, MSW

DPH Staff: Tony Wagner, Monique Zmuda, John Luce, M.D., Hiro Tokubo, Melinda Garcia, Gayling Gee, Ken Jensen, Alison Moed, Alan Gelb, M.D., Melissa Welch, M.D., Catherine Thurow, Connie Young and Delores Gomez

Absent: Commissioner Edward A. Chow, M.D.

1) CALL TO ORDER

2) APPROVAL OF MINUTES OF FEBRUARY 22, 2000

Action Taken: The Committee unanimously adopted the minutes of March 14, 2000.

3) **PRESENTATION OF A PROJECT ON HIGH UTILIZERS OF ACUTE MEDICAL INPATIENT SERVICES**

(Alicia Fernandez, M.D., Director of Inpatient Services, SFGH Dept. of Medicine)

Dr. Fernandez presented a research study on high utilizers of the San Francisco General Hospital inpatient medical service. The preliminary data show the following:

- High utilizers of the inpatient medical service, defined as patients with three or more hospitalizations in a year's time, make up 13% of our patients
- High utilizers account for 36% of hospital days at SFGH
- High utilizers use Community Health Network (CHN) services (Including inpatient, emergency department and primary care clinics), five times as often as non-high utilizers
- High utilizers appear to be well linked to the CHN primary care clinic system
- Almost three quarters of high utilizers patients have at least one appointment within one year following their first admission, compared to less than half of the non-high utilizers
- High utilizers are disproportionately male, African American and homeless
- High utilizers have high rates of substance abuse and alcoholism
- High utilizers have high rates of psychiatric illness

Dr. Fernandez reported that plans are being made for a conference, "Creating a Coordinated System of Care for High Utilizers of the San Francisco Medical Service," scheduled for Monday, June 26, 2000, 8:30 a.m. to 4:30 p.m., at the Laurel Heights Conference Center.

Commissioner Guy supports the presentation of further studies to the Joint Conference Committee and having a dialogue at the policy level.

Comments and questions raised:

- What can primary care do to prevent hospitalization?
- How do you manage a population of patients who are complex and may not fit into a traditional model of care?
- The high utilizers are also in the Community Health Network primary care clinics.
- How do we create a new model of care for these complex patients?
- Case management is needed for these complex patients; but the hospital care is still needed.

President Guy encouraged the discussion around primary care and incorporating these discussions into the Department's Strategic Plan.

Commissioner Monfredini feels it's important for the full Commission to hear this presentation. It was suggested to calendar this presentation at the full Commission for May 16, 2000.

Commissioner Monfredini thanked Dr. Fernandez for her presentation.

4) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**

None.

5) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**

None.

Closed session started at 4:40 p.m.

Present in the closed session were Commissioner Monfredini, Commissioner Guy, Tony Wagner, Hiro Tokubo, Melinda Garcia, Alan Gelb, M.D., John Luce, M.D., Catherine Thurow, Monique Zmuda, Gayling Gee, Delores Gomez, Ken Jensen, Connie Young, Alison Moed, Melissa Welch, M.D., and Sandy Mori.

6) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

ACTION ITEM: **TO APPROVE CLOSED SESSION MINUTES OF FEBRUARY 22, 2000 AND MARCH 14, 2000**

Action Taken: The Committee approved the closed session minutes of February 22, 200 and March 14, 2000.

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS**

Closed session ended at 5:25 p.m.

7) **RECONVENE IN OPEN SESSION**

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a))

Action Taken: The Committee voted not to disclose any discussions held in closed session.

The meeting was adjourned at 5:30 p.m.

Sandy Ouye Mori
Executive Secretary to
the Health Commission

Roma P. Guy, M.S.W.
President

John I. Umekubo, M.D.
Vice President

Edward A. Chow, M.D.
Commissioner

Ron Hill
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sanchez, Jr., Ph.D.
Commissioner

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CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Sandy Ouye Mori
Executive Secretary

TEL: (415) 554-2666

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AGENDA

**JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING**

Tuesday, May 9, 2000

3:30 - 5:30 p.m.

1001 Potrero Street, Room #2A6

San Francisco, CA 94110

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**Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.**

- 1) **CALL TO ORDER**
- 2) **FOR APPROVAL: MINUTES OF APRIL 11, 2000**
- 3) **FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE**
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
- 4) **FOR DISCUSSION: PATIENT CARE REPORT**
(Dolores Gomez, RN, MS, Chief Nursing Officer, SFGH Associate Administrator for Acute Care Services, CHN)

- 5) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Ken Jensen, Chief Financial Officer, CHN)
- 6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**
- 7) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION
- 8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF APRIL 11, 2000

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QUM
Hiroshi Tokubo, Director of QM
Alison Moed, Director of Risk Management

- 9) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM))

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

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American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

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For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Rachel Arnstine O'Hara, Clerk
City Hall, Room 362
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4683

Telephone: (415) 554-6171/554-6075
Fax: (415) 554-6177
E-mail: Rachel_ArnstineO'Hara@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us.

City and County of San Francisco
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Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

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MINUTES

**JOINT CONFERENCE MEETING
FOR
SAN FRANCISCO GENERAL HOSPITAL**

**Tuesday, May 9, 2000
3:30 p.m.**

**1001 Potrero Avenue, Room #2A6
San Francisco, CA 94110**

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1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Commissioner Harrison Parker, Sr., DDS, at 3:30 p.m.

Present: Commissioner Harrison Parker, Sr., DDS

DPH Staff: Gene O'Connell, Connie Young, Tony Wagner, Hiro Tokubo, Beth Maloney, Melinda Garcia, Delores Gomez, Alan Gelb, M.D., and Catherine Thurow.

Absent: Commissioner Edward A. Chow, M.D.
Commissioner Lee Ann Monfredini

1) CALL TO ORDER

2) APPROVAL OF MINUTES OF APRIL 11, 2000

Action Taken: The Committee adopted the minutes of April 11, 2000.

Note: Dr. Alan Gelb, Chief of Staff for SFGH, introduced Beth Maloney, new Director of the Medical staff office. She came from UCSF and was formerly with SFGH a few years ago.

3) **HOSPITAL HEALTHCARE UPDATE**

(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)

CQI Task Force Update Reports

In an effort to improve performance processes within San Francisco General Hospital Medical Center, SFGHMC Executive Committee charges the formation of various CQI Task Forces. In charging the formation of a CQI Task Force, a member from the SFGHMC Executive Committee is assigned to the Task Force so to serve as an administrative liaison to the Executive Committee. In addition to the assigning of a member-liaison, the CQI Task Force reports into Executive Committee on a quarterly basis. Following, are the most recent update reports that SFGHMC Executive Committee has received from their charged CQI Task Forces:

Performance Appraisal CQI Committee

Charge: To improve the process of completing annual performance appraisals so that they can be completed in a more timely manner.

Committee Composition:

- Human Resources Services
- Education and Training
- Licensing/Accreditation
- MHRF
- Acute Care
- Rehabilitation Services
- Acute Psychiatric Nursing
- Pharmaceutical Services
- Quality Management
- Specialty Care
- LHH
- Medical Social Services
- Respiratory Care Services
- Food and Nutrition Services

Current Status:

A survey of Management Forum participants determined that 78% of managers would like to see the format or the content of the current tool (performance appraisal) revised and 66% would like to see the process changed.

CQI Committee has created a new tool and is currently in 2-step pilot process. The first phase of the pilot entails customization of the tool to the pilot department as well as assigning each pilot department a "CQI team member mentor" to help the department with the evaluation process. The first phase of the pilot will end on 6/30/2000 when the performance evaluation appraisals are due. In July, the CQI committee will meet with each Phase I pilot manager to evaluate format, content, and the process of the evaluation. Using this information, the package will be revised in preparation for Phase II. Phase II will be the same as Phase I with the exception that participating pilot departments will be different. Phase II is to be completed by September 20th.

Ms. O'Connell reported the performance appraisal report will go to the full Commission.

Security Alias Names

Charge: Promote employee, patient, and visitor safety by ensuring the anonymity of patients where disclosure of their identity would place them at risk for threats, acts of violence, or invasion of privacy.

Committee Composition:

- Acute
- Nursing
- Information Systems
- Institutional Police
- Blood Bank
- Volunteers
- Critical Care
- Admitting/Eligibility
- Trauma
- Emergency
- Medical Social Services
- Medical Records
- Specialty – OR
- Quality Management

Current Status:

The CQI Task Force has found that the most effective method of alerting providers that a patient has a security alias is by placing a “flag” in the patient’s electronic medical record on INVISION. The “flag” alerts providers and anyone trying to access the patient’s names or files of the patient’s security alias by placing a banner (i.e. **RESTRICTED INFORMATION, DIVULGING THIS PATIENT’S INFORMATION IS RESTRICTED TO AUTHORIZED PERSONNEL ONLY**) across each of the patient’s medical record computer screens. Security Alias Names will be assigned locally at the Nursing Unit of Admission and will be assigned consequently with each new internal transfer.

In putting the “flagging” system into place, Information Systems and the Department of Education and Training will be training all staff who access patient records how to utilize the patient name security system. Staff will also be trained on the criteria, enclosed in the hospital policy and procedure, determines the necessity of a security alias name.

EMTALA

Charge: To develop, implement, and monitor procedures to ensure that all parts of SFGH are in compliance with the EMTALA regulations

Committee Composition:

- Emergency Department
- Labor and Delivery
- Women’s Clinic
- Risk Management – UCSF and SFGH
- Ambulatory Care: Primary and Specialty Clinics
- Medical Records
- House Supervisor
- PES
- Patient Referral and Assistance
- Urgent Care
- Admitting/Registration
- Ortho Clinic

Current Status:

The deliverables from this committee include the drafting of a hospital-wide policy and procedure for EMTALA compliance, development of departmental policies and procedures in those areas that provide urgent/ emergent services and screening examinations, revising existing hospital transfer policies, developing guidelines for investigating possible EMTALA violations on the part of other hospitals (i.e. patient dumps), developing a training program for hospital employees, and implementing monitoring mechanisms for ensuring ongoing compliance.

This committee has been meeting every other week since March. Taking regulations that were developed for emergency departments and applying them to clinic settings is proving to be very tricky. However, the committee members have been highly dedicated to working through these difficulties and have made substantial progress. A draft hospital policy and procedure is completed as well as many of the supporting documents. Additionally, many of the clinics are already proceeding with making operational changes.

GOALS OF SFGH

In further discussing performance improvement priorities, SFGHMC Executive Committee has determined the following projects as their priorities for FY 2000-2001 in meeting the changes of:

- Development of the SB 1953 Master Plan
- Wound Care Center
- Achieving Level I Trauma Designation
- JCAHO Planning
- Identifying Appropriate Levels of Care for SFGH/MHRF Patients
- Interfaces with Mental Health/Substance Abuse

UPDATE STATUS ON WOUND CARE CENTER PROJECT

The 4C Wound Care Initiative is progressing along towards implementation. The second round of interviews for the Nurse Practitioner positions will be completed by May 10th. Representatives from Surgery, Emergency Department, Surgical Clinics and Substance Abuse Services participate in the interviewing panel as well as the selection. Two candidates for the Services should be hired by end of May.

Administrative and Facilities staff have already rounded 4C to discuss and determine room assignments and renovations to the Unit. Equipment and supply lists for the unit have been set up and are on order and Eligibility processes and billing forms are in development.

Meetings are scheduled with Anesthesia and Infectious Diseases Services to discuss Sedation, Pain Management and Antibiotic Treatment protocols for the Soft Tissue Infection population. Planning is also underway for the development of the most appropriate model for substance abuse counseling and referral to methadone treatment, focused around 4C Wound Care Center Activities. The need for respite beds for this population has also been identified by 4C staff and has been brought to the attention of the larger committee.

SFGH continues to work with Population Health and Prevention through the larger committee to ensure coordination of activities and efforts.

UPDATE STATUS ON THE DEVELOPMENT OF A PHARMACY BENEFITS MANAGEMENT SERVICES PLAN

1. Eligibility/Information Systems Issues

A group with members representing pharmacy, eligibility, registration, finance, information systems, and compliance met weekly in March. The following major issues (not an inclusive list of all issues discussed) were clarified with CHN Leadership and/or resolved for purposes of developing an RFP for pharmacy benefits management services:

- Eliminate retroactive patient/third-party (i.e. Medi-Cal) billing
- Allow contracted pharmacies to bill SF County for unmet Medi-Cal share-of cost
- Develop mechanism(s) to apply medical and other services to Medi-Cal share-of-cost payment at the time of the visit/other service (include Consortium Clinics)
- Do not allow contracted pharmacies to waive \$2 co-pay; develop 'prior authorization' of co-pay waiver at the time of Eligibility screening
- Provide discharge medication services through SFGH pharmacy
- Establish 'maximum allowable charge' structures for selected pharmaceuticals (use Medi-Cal model)
- Provide/develop interfaces with hospital information systems and selected pharmacy benefits manager
- Require electronic claims submissions by pharmacy benefits manager to CHN
- Require prescriptions be signed by CHN-recognized providers
- Accept eligibility information supplied by Consortium Clinics (currently, patient must also go through CHN eligibility processes)
- Non-prescription drugs and nutritional supplements distribution not to be part of the pharmacy benefits management package

The group will meet on an as-needed basis to address additional issues that may arise. The individual, affected departments will implement policy decisions. Information that was collected from other counties that have implemented PBMs indicate that IS issues between the county and the PBM were major stumbling blocks. This issue will be monitored and hopefully ameliorated by continuing to work closely with the IS department as the PBM contractor is selected.

2. *Development of RFP*

The first draft of the description of need and scope of desired services to be published in a request for proposal (RFP) for a pharmacy benefits management (PBM) company was forwarded to the Contracts Office on May 5, 2000. The RFP will require additional work and time before it finalized, and publication is targeted for May 26.

A recently hired SFGH Pharmacy Director joined the organization on April 24. He will work with the CHN Director of Pharmaceutical Services to finalize the language for the RFP.

3. *Staff Reassignments*

The following activities have occurred to date:

- Open CHN pharmacy positions identified, and staff to potentially be reassigned identified
- Staff reassignment plan developed and approved by Human Resources
- Preliminary meeting with labor (SEIU) representatives held to outline reassignment plan; and an initial meet-and-confer session was held.
- Meetings with CHN pharmaceutical services staff to outline reassignment plan
- Parts of plan implemented to address staffing shortages throughout the CHN (e.g. Board of Pharmacy requirement for pharmacist vacancy in Jail Health necessitated reassignment of a staff pharmacist)

A preliminary 'meet-and-confer' session was held on April 28 with representatives of SEIU Locals 250 and 790. Representing CHN at the meeting were Rod Auyang, Human Resources; and Sharon

Kotabe and Fred Hom, pharmacy administration. Labor has agreed to submit, in writing; specific information they are requesting regarding the proposed closure of the outpatient pharmacy and the proposed staff reassignment plan. Labor continues to hold the belief that the closure of the outpatient pharmacy constitutes a breach in the memorandum of understanding between SEIU and the City. Local 250 (and perhaps Local 790 as well) objects to extending the pharmacy registry contract and continues to believe that the pharmacy registry contract is linked to the proposal to close the outpatient pharmacy (CHN representatives do not share this opinion.)

4. *Communications Plan*

A communications 'game plan' was developed on May 3, 2000. Strategies regarding communicating outpatient pharmacy service changes were outlined. Key strategists, publics and communicators were identified, and major tactics or deliverables were agreed upon. Work has begun on development of a visual representation of how the 'new' system will operate, and 'frequently asked questions' (FAQ) sheets.

PSYCHIATRY

In meeting with the budget initiative of closing 21 psychiatry beds, a memo was sent out to all Psychiatry staff on May 3rd encouraging them to voluntarily apply for a new position within the Department. To review the list of available positions, all staff were given a contact name at Human Resources Services. The memo also indicates that we would have to commence mandatory reassignment on May 10th, beginning with staff with the least seniority in each classification. A seniority roster was made available in the Psychiatry Administrative Suite. Under the direction of the CHN, there have also been meetings to determine appropriate triaging of patient flow and placement.

Commissioner Parker inquired about the cultural competency in the psychiatry units, the status of the billing system, violence prevention in the workplace, and the filling of critical vacant staff positions.

At a future Joint Conference Committee meeting, the proposed Departmentwide harm reduction policy will be an agenda item.

This year the Commission would like to have one of its meetings in the SFGH Carr Auditorium. Ms. O'Connell recommended at this meeting, an annual SFGH report could be a main agenda item.

4) **PATIENT CARE REPORT**

(Dolores Gomez, RN, MS, Chief Nursing Officer, SFGH Associate Administrator for Acute Care Services, CHN)

Plan for the Provision of Patient Care

The annual review of the Hospital Plan for Providing Patient Care at San Francisco General Hospital is currently under review/revision for presentation at the SFGHMC Joint Conference Committee in June. This policy defines the hospital mission/goals, identifies the population served, and describes the structure and processes utilized. The Joint Commission utilized this policy as a "primary" policy and a foundation to focus many of their survey activities while at the hospital. Review includes updating our statistics, budgetary impact/implications, and clinical review of programs and services.

New Appointments

The budget problems have required SFGH to look critically at each and every position and make decisions on what position to keep vacant and which to proceed forward and fill. Many so called administrative on non-direct care positions have been kept vacant while SFGH has focused on hiring into the direct care clinical positions. This has allowed SFGH to maintain staffing and quality standards for care provision.

There are, however, key management positions that SFGH has had extreme difficulty in recruitment that are required for on going hospital operations. Ms. Gomez announced the following individuals as new members of the nursing management team:

Mark Crider joins the Mental Health Rehabilitation Facility as the new Director of Nursing. Mark comes from Walnut Creek Psychiatric Hospital in Pennsylvania, and has extensive knowledge in psychiatric nursing and organizational behavior.

Susan Massey joins the Surgery Department as a Nurse Manager in the Operating Room. Susan comes to us with extensive surgical nursing and management experience from the Sutter HealthCare System.

Retirement

Deanna Mooney, Director for the Surgical Department has announced her retirement from San Francisco General Hospital Medical Center after over 30 years of service. She will be leaving her position at the end of June. Recruitment activities for a replacement will begin in the Fall.

Labor Negotiations

Citywide Local 250 SEIU negotiations are underway. This Union represents many classifications at the hospital, both in the non-direct and direct care areas. In addition, Local 790 SEIU negotiations are also underway, which is the RN bargaining unit in the Department of Public Health. The Teamsters who represent nursing management positions have also begun to meet this week. Hopefully, these contracts will be completed by the end of May/early June for planning purposes for the next budget year.

5) STATEMENT OF REVENUES AND EXPENDITURES

(Ken Jensen, Chief Financial Officer, CHN)

Mr. Jensen submitted the March Revenue and Expense Summary, (Attachment A).

6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL

None.

7) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION

None.

The Committee went into closed session at 4:23 p.m.

8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF APRIL 11, 2000

Action Taken: The Committee approved the closed session minutes of April 11, 2000.

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Closed session ended at 4:55 P.M.

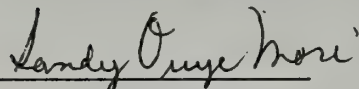
Individuals in the closed session were Commissioner Harrison Parker, Sr., DDS, Gene O'Connell, Connie Young, Delores Gomez, Hiro Tokubo, Dr. Alan Gelb, Melinda Garcia, Beth Maloney, Tony Wagner, Catherine Thurow and Sandy Mori.

8) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a))

Action Taken: The Committee voted not to disclose any discussions held in closed session.

The meeting was adjourned at 4:56 p.m.



Sandy Ouye Mori
Executive Secretary to
the Health Commission

Attachment (1)

San Francisco General Hospital

Revenue and Expense Summary

March 2000

The eight-month report for San Francisco General Hospital presented to the Health Commission indicated that the negative variance from budget for the 99/00 fiscal year would be \$6.1 million, after implementation of the initiatives. The financial situation for San Francisco General Hospital as of the end of March, 2000 shows that the deficit is maintained at the same level of \$6.1 million. Additionally, the \$10 million reduction in Disproportionate Share reimbursement is reflected, and a supplemental funding request will be presented to the Health Commission in May. Personnel services may be below budget at year-end if vacancies and restrictions on the use of overtime and as-needed personnel continued.

Specifically:

- **REVENUE** is expected to be \$48.8 million <\$48.8M>
under expectations (10.8%), of which \$29.5 million is due to a change in accounting for the net revenue of SB1255 and GME instead of booking gross revenue to include intergovernmental transfer. There is a corresponding reduction in operating expenses to reflect the omission of intergovernmental transfer. Bad debt and unreimbursed accounts explains the reduced patient revenue of \$6 million, and SB855 (Disproportionate Share) reduction accounts for \$10 million, as a result of further erosion of the DSH pool. Other factors include \$2.3 million reduction of capitation IHSS revenue, \$2 million shortfall of Short Doyle payments, and \$1 million increase in Realignment revenue.
- **EXPENSES** are expected to be \$32.7 million \$32.7M
(7.2%) better than expected. The exclusion of SB1255 & GME intergovernmental transfers account for \$30 million; materials and services are \$3.3 million better than budget; and IHSS expenditures are \$1.6 million lower than expected, salaries are \$0.7 million better than budget; and capital outlay is expected to be \$0.5 million above budget. It should be noted that "non-controllable" employee benefits are expected to be \$2.4 million over budget.

Net Variance (3.6%)

<\$16.1M>
=====

• **STATISTICS**

YTD - Net Revenue/adjusted patient day	\$1,344
Cost/adjusted patient day	\$1,408
FTEs (incl. UC)/adjusted occupied bed	4.9
YTD Average Daily Census - total	434
- excl. MHRF	307

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AGENDA

**JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING**

Tuesday, June 13, 2000

3:30 - 5:30 p.m.

1001 Potrero Street, Room #2A6

San Francisco, CA 94110

Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.

- 1) **CALL TO ORDER**
- 2) **FOR APPROVAL:** **MINUTES OF MAY 9, 2000**
- 3) **FOR DISCUSSION:** **HOSPITAL HEALTHCARE UPDATE**
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
- 4) **FOR DISCUSSION:** **PATIENT CARE REPORT: PRESENTATION ON THE MENTAL HEALTH REHABILITATION FACILITY (MHRF)**
(Mozettia Henley, RN, DScN, Director of MHRF)
**Report*

- 5) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Ken Jensen, Chief Financial Officer, CHN)
- 6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**
- 7) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION
- 8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF MAY 9, 2000

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

- 9) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM))

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

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MINUTES
JOINT CONFERENCE MEETING
FOR
SAN FRANCISCO GENERAL HOSPITAL

Tuesday, June 13, 2000
3:30 p.m.
1001 Potrero Avenue, Room #2A6
San Francisco, CA 94110

1) **CALL TO ORDER**

The regular meeting of San Francisco General Hospital was called to order by Commissioner Lee Ann Monfredini, at 3:35 p.m.

Present: Commissioner Edward A. Chow, M.D.
Commissioner Lee Ann Monfredini

DPH Staff: Gene O'Connell, Tony Wagner, Hiro Tokubo, Melinda Garcia, Connie Young, John Luce, M.D., Alan Gelb, M.D., Alison Moed, Hiro Tokubo, Catherine Thurow, Joseph Pendon, Ken Jensen, MHRF Executive Staff

2) **APPROVAL OF MINUTES OF MAY 9, 2000**

Action Taken: The Committee adopted the minutes of May 9, 2000.

3) **HOSPITAL HEALTHCARE UPDATE**

(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)

HARM REDUCTION MODEL PROGRAMS

At San Francisco General Hospital Medical Center, there are a number of programs that utilize the

harm reduction model in their approach to caring for patients. Understanding that the Commission would like to learn more about the different programs that exist in the Department, the following is a list of programs that adopt this model:

Medicine

- Pain Consultation Clinic
- HIV and Substance Abuse services – (i.e. promoting safer sex practices, limiting sexual partners, avoiding sex for drug exchanges, needle exchange programs, no needle sharing, reducing the amount of alcohol or drug use, getting clients to clinic at first sign of an infection or abscess)

Surgery

- Wound Care Clinic

Psychiatry

- 4P Multi-diagnosis/Case Management Detoxification Unit
- Psychiatric Emergency Services- Crisis Resolution Team
- Division of Substance Abuse and Addiction Medicine which includes:
 - Substance Abuse Consultation Service
 - Primary Care Substance Use Service
 - Ward 93: Opiate Treatment Outpatient Program

IMPACT OF STANFORD'S NURSING STRIKE ON SFGHMC

Stanford is currently experiencing a nursing strike that is affecting their ability to care for certain patients. Many hospitals within the Bay Area have been affected by this strike, accepting many of their trauma and pediatric patients. At this time, SFGH along with Santa Clara Valley Medical Center, are on stand-by to assist Stanford in accepting trauma transfers. If the need arises to transfer trauma patients, Santa Clara Valley Medical Center (SCVMC) is contacted first. If SCVMC is not able to accept any more trauma transfers, the trauma patients are then transferred to San Francisco General Hospital. Up until now, SCVMC has been able to accept all of Stanford's trauma transfers; therefore, making Stanford's Nursing Strike impact on San Francisco General Hospital negligible.

DECREASE OF MEDICAL-SURGICAL BEDS

Included in next year's budget is the proposal to decrease the Medical-Surgical Units by 20 beds. The following below shows the units that will be affected:

Unit	Number of beds decreased
4D	2
5A	4
5C	3
5D	3
6A	1
ICU	4
4B	1
Neonatal ICU	1
6C	1
Nursery*	1*
Total Adult Beds Decreased:	20*

** Nursery bed not counted in Adult Bed Reduction*

Associated with this 20-bed decrease is a 30.1 FTE decrease. Impact of staff reassignment for permanent staff is minimal since there are significant vacancies within the acute care areas. Breakdown is as follows:

Med-Surg RNs

Unit	Old Model	New Model	Vacancies	Variance
5A	22.3	18.0	0.05	+4.25
5C	20.2	18.9	1.1	+0.2
5D	23.4	22.3	2.0	-0.9
6A	15.7	16.1	1.7	-2.1
4D	24.3	24.0	1.9	-1.6

Med-Surg LVNs

Unit	Old Model	New Model	Vacancies	Variance
5A	6.0	4.2	0	+1.8
5C	14.2	12.5	1.8	-0.1
5D	15.2	14.8	0.6	-0.2
6A	12.2	11.6	1.3	-0.7
4D	15.9	16.0	2.75	-2.85
Float Pool	No change	No change	3.6	-3.6

There will be **no** impact to permanent staff in the following areas due to vacancies:

4B
ICUs
NNICU/Nursery
6C Birth Center

INPATIENT PSYCHIATRY BEDS

San Francisco General Hospital Medical Center is continuing to work with various key individuals within the Department of Public Health to address the issues facing San Francisco General Hospital's Inpatient Psychiatry Beds:

- SFGH has been working very closely with Nancy Presson of PHP to establish and monitor performance measures related to the 21 inpatient psychiatry beds.
- Discussions with Marc Trotz have also occurred to address the ability to expand supportive housing services and board and care.
- SFGH is also in the process of identifying Mental Health Rehabilitation Facility residents who can be moved to Laguna Honda Hospital so to allow for appropriate admissions from Psychiatry. I will continue to update you as we progress.

ANNOUNCEMENTS

As previously reported, Joseph Pendon, Director of Medical-Surgical Services at San Francisco General Hospital Medical Center will serve as Interim Chief Nursing Officer/Inpatient Director. A Search Committee will be appointed by July 1, 2000 to begin steps for recruiting a permanent Chief

Nursing Officer. Also during this time, there will be a review of current organizational assignments and a determination of what other organizational changes may need to occur.

Commissioner Chow encouraged administration to closely monitor the utilization, clinical issues, and finances of the 21 psychiatry beds. Mr. Jensen and Ms. O'Connell assured the Commission that close monthly monitoring will take place.

4) **PATIENT CARE REPORT: PRESENTATION ON THE MENTAL HEALTH REHABILITATION FACILITY (MHRF)**

(Mozettia Henley, RN, DScN, Director of MHRF)

Dr. Henley introduced members of her Executive Staff: Liz Gray, Lucy Fisher, John Butts, Glenn McClintock, Mark Crider, Ernestina Carrillo, Norma Jo Waxman and Joe Hartog.

The Executive Staff presented an overview of the MHRF, including the history, an organizational chart, the CHMS system and care, the rehabilitation continuum, the program goals, the various descriptions of the residents, and challenges. For a copy of the presentation contact the Commission Office (554-2666).

Commissioner Chow raised potential policy issues of the original intent of the MHRF and where the MHRF stands in the continuum of care for physical and mental health. He advocated for one system of care within the Department.

Commissioner Monfredini requested a follow-up discussion on these issues at a future meeting.

5) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Ken Jensen, Chief Financial Officer, CHN)

Mr. Jensen reported a decrease in the number of sponsored patients. He is working with Monique Zmuda, DPH Chief Financial Officer, to analyze the figures.

5) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**

None.

7) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**

None.

The Closed Session began at 4:55 p.m.

Individuals in the Closed Session were: Commissioner Monfredini, Commissioner Chow, Gene O'Connell, Tony Wagner, Melinda Garcia, Connie Young, John Luce, M.D., Alan Gelb, M.D., Alison Moed, Hiro Tokubo, Joseph Pendon, Ken Jensen, Catherine Thurow, Sandy Mori.

8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

Action Taken: The Committee approved the Closed Session minutes of May 9, 2000, with the correction on Commissioner Parker's name

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Closed Session ended at 5:05 p.m.

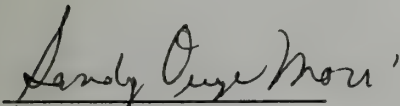
9) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a))

Action Taken: The Committee voted not to disclose any discussions held in Closed Session.

Commissioner Monfredini announced there will be no JCC-SFGH meeting in the month of August.

The meeting was adjourned at 5:06 p.m.



Sandy Ouye Mori
Executive Secretary to
the Health Commission

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Department of Public Health
101 Grove Street, Room #311
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AGENDA

**JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING**

Tuesday, July 11, 2000

3:30 - 5:30 p.m.

1001 Potrero Street, Room #2A6
San Francisco, CA 94110

Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.

- 1) **CALL TO ORDER**
- 2) **FOR APPROVAL:** **MINUTES OF JUNE 11, 2000 JCC-SFGH MEETING**
- 3) **FOR DISCUSSION:** **HOSPITAL HEALTHCARE UPDATE**
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
- 4) **FOR DISCUSSION:** **PATIENT CARE REPORT: PRESENTATION ON THE MENTAL HEALTH REHABILITATION FACILITY (MHRF)**
(Joseph Pendon, RN, MSN, Acting Chief Nursing Office)
**Report*

- 5) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Ken Jensen, Chief Financial Officer, CHN)
- 6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**
- 7) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION
- 8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF JUNE 11, 2000

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM .
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

9) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM))

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

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MINUTES

**JOINT CONFERENCE COMMITTEE MEETING
FOR
SAN FRANCISCO GENERAL HOSPITAL**

Tuesday, July 11, 2000
3:30 p.m.
1001 Potrero Avenue, Room #2A6
San Francisco, CA 94110

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1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Chairperson, Commissioner Lee Ann Monfredini, at 3:35 p.m.

Present: Commissioner Lee Ann Monfredini

Absent: Commissioner Edward A. Chow, M.D.

DPH Staff: Gene O'Connell, Ken Jensen, Alan Gelb, M.D., John Luce, M.D., Melissa Welch, M.D., Hiro Tokubo, Melinda Garcia, Connie Young, Monique Zmuda, Joseph Pendon, Alison Moed, Catherine Thurow, Diana Guevara

2) APPROVAL OF MINUTES OF JUNE 13, 2000

Action Taken: The Committee adopted the minutes of June 13, 2000.

3) HOSPITAL HEALTHCARE UPDATE

(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)

IMPACT OF CHW/SUTTER LOCAL 250 STRIKE ON SFGHMC

On Thursday, July 6th, Local 250 workers staged a one-day strike at nine hospitals around the Bay Area, many being either CHW or Sutter affiliated. Both Christine Wachsmuth and Joseph Pendon were involved in conference calls coordinated by CHW. In the end, the impact to San Francisco General Hospital Medical Center was minimal.

UPDATE ON RECRUITMENT EFFORTS IN SELECTING A CHIEF NURSING OFFICER

Efforts in recruiting a new Chief Nursing Officer are on their way. We are in the process of encouraging external candidates to apply as well. In selecting a new Chief Nursing Officer, a Selection Committee has been created. It will be chaired by Rita Smith, RN, MSN, Director of Critical Care Nursing, and Mary Jo Webb, Director of Emergency Nursing. We hope to begin conducting interviews starting in August and to have the new Chief Nursing Officer begin in September 2000.

TRAUMA PROGRAM GRANT

SFGH Trauma Center has collaborated with the Emergency Medical Services Agency in the awarding of a State-funding grant to evaluate the City of San Francisco's trauma services. Key objectives of the grant are:

- Create a new trauma services plan for the City of San Francisco (last revised in 1990)
- Study gaps and make recommendations on the trauma system of care to include analysis of role of community hospitals; regional cooperation between trauma centers in the Bay Area; aeromedical access to services and leadership role of a Level 1 Trauma Center in the community
- Development of joint audit committee for trauma care review, and
- Assist SFGH in preparations to meet new Title 22 and American College of Surgeons standards prior to Trauma Center designation site survey.

TREASURE ISLAND MULTI-AGENCY DISASTER EXERCISES

SFGH, EMS Agency and SFFD EMS Division will be joining the SFPD in disaster exercises on Treasure Island on July 19 and 20. The Police Department will be running a number of complex scenarios on the Island related to their field operations and have invited SFGH to exercise our emergency helicopter landing procedures using Rolf Field (Caesar Chavez and Potrero Street). The EMSA will be coordinating the aeromedical activation component of the drill and SFGH staff will be working with REACH helicopters and the new 911 communications center to exercise the hospital's response.

MENTAL HEALTH REHABILITATION FACILITY (MHRF) WELLNESS COMMITTEE

Ms. O'Connell announced the formation of the MHRF Wellness Taskforce. This Task Force is being formed with the support of Mitchell Katz, Director of Public Health; Mozettia Henley, MHRF Program Director and Ms. O'Connell. Mark C. Crider, Director of Nursing for the MHRF, will lead the formation and develop recommendations addressing the following:

- Improving staff morale;
- Conflict management and resolution;
- Workload issues; and
- Enhancing the resident rehabilitation model

The Task Force will present the recommendations to Dr. Katz and Ms. O'Connell within 60 days of the Task Force's formation. The Task Force will include twelve members from the MHRF staff representing the various disciplines and representatives of Locals 790, 250, and 21 will be asked to serve on the Wellness Task Force. The Task Force will also develop recommendations of how the MHRF will measure its success in addressing the items above. A portion of the time during the initial formation of the Task Force will be focused on developing the Task Force as a team to facilitate success in accomplishing the charge within the allotted time frame.

Ms. O'Connell will continue to update the Joint Conference Committee as recommendations are forwarded.

PATIENT FLOW FROM MHRF TO LAGUNA HONDA HOSPITAL

In order to identify appropriate patient placement, 26 of the residents at the MHRF were evaluated for possible placement at LHH. Screening by the combined LHH/MHRF Committee occurred resulting in seven patients going to LHH with one more leaving tomorrow. A defined process is in place allowing for further evaluations and placement to continue in an ongoing fashion.

DIVERSION

The EMS Section of the San Francisco Department of Public Health is proposing that Critical Care Diversion be eliminated on August 1, 2000 at 12:01 a. m. The capability of Total Diversion will remain unchanged as outlined in the EMS Section Diversion Policy, Reference #8010. There will be a two-week public comment period on this policy change ending July 14, 2000. The hospital will be reviewing and responding to the policy.

OPENING OF THE WOUND CARE CENTER – 4C

The expansion of the 4C Wound Care Center was a key proposal of the DPH Task Force on Management of Patients with Abscesses and Injection Drug Users. This proposal entailed the development of an Integrated Soft Tissue Infection Service (ISIS), whose charge is to evaluate patients presenting soft tissue infections and develop more appropriate ambulatory care protocols and systems for treatment.

An ISIS team, consisting of Department of Surgery faculty, nurse practitioners, and 4C nursing staff, began providing ambulatory services on July 5 to patients with soft tissue infections. Under the leadership of Drs. David Young, Hobart Harris, Chen Lee, Nurse Practitioner Gay Gilliland, and 4C Nurse Manager Jacquelyne Caesar, the service is providing daily evaluation and treatment of these patients. In the first six days of operation (including half-day clinics on Saturday and Sunday), ISIS has provided the following:

- 43 total patient encounters (9 follow-up visits)
- 34 individual patients evaluated
- 16 abscess treatment with incision, drainage and return visit
- 13 cellulitis treatment with antibiotics and return visit
- 1 wound debridement with antibiotics and return visit
- 3 hospital admissions with OR utilization
- 1 PES referral with subsequent admission

Concurrently, Substance Abuse Services and Medical Social Services are providing substance use evaluation for treatment and referrals for shelter and other concrete services. A weekly multidisciplinary meeting of ISIS, Medical Social Services, Substance Abuse Services, Emergency Department, Anesthesia, PHP, Pharmacy, OR Nursing, Patient Accounting and Administrative representatives has been initiated to review and resolve operational and clinical issues, with the goal

of refining and developing services over the next fiscal year. Program evaluation will be another key aspect of discussion for this group.

All services have been extremely collaborative in this venture. This proposal has gotten off to an excellent start through the commitment of numerous individuals.

Commissioner Monfredini requested a copy of the EMS Section Diversion Policy, Reference #8010.

4) PATIENT CARE REPORT

(Joseph Pendon, RN, MSN, Acting Chief Nursing Office, SFGHMC)

PILOT OF THE CLINICAL INSTITUTE ASSESSMENT FOR ALCOHOL (CIWA-Ar) TOOL

An interdisciplinary SFGH team of physicians, pharmacists, and nurses commenced a pilot on May 8, 2000 utilizing the Clinical Institute Assessment for Alcohol (CIWA-Ar) Tool, in an effort to standardize medication therapy in managing those patients with impending or actual alcohol withdrawal syndrome. This tool is highly validated with the purpose of determining the level of medication to be administered based on the patient's alcohol level. Previously there is no standardized practice for treating these patients; the level of medication treatment has been determined by the preference of the provider. The ultimate goal of piloting the tool at SFGH is to standardize the use of the tool throughout the Hospital and adhere to our medication guidelines for treatment of alcohol withdrawal. Standardization of practice will benefit the patients by creating consistency of care and in preventing complications that may arise from withdrawal.

The initial findings from the pilot indicates that the tool is successful and effective in standardizing the practices of medication treatment for these patients based on their alcohol level. Because of this, the pilot will be expanded to the unit of 4B (Step Down). Training on how to utilize the tool as well as encouraging other providers to utilize the tool will commence on July 20th. Updates on this pilot will be reported to JCC-SFGH as new findings and results become available.

NURSE TRAINING PROGRAM

Due to the shortage and recruitment obstacles related to the areas of critical care and labor and delivery, SFGH is now currently offering nursing training programs in these areas with the hope of training and retaining the trainees in the program. This will aid us ultimately in decreasing the amount of over-time and per diem use in these areas. At this point, all of the trainees have successfully completed their training.

Four nurses (3.6 FTEs) are currently participating in Critical Care Nursing Training Program. Two of these nurses are experienced nurses and the remaining two are new nursing graduates.

In L&D, there were also four nurses who participating in the training program. Two of them have already moved onto permanent positions. This training is particularly cost effective due to our collaboration with an outside Nursing Consortium Training Program. Due to the success of this training program, there is the plan to provide a second training program in L&D pending release of vacant positions.

SFGH TO BECOME A "BABY-FRIENDLY HOSPITAL"

Within the next three weeks, SFGH will file a certificate of intent to become the first "Baby-Friendly Hospital" in the City of San Francisco. This "Baby-Friendly Hospital" Initiative is under the care of the Healthy Children 2000 Project and is a worldwide project of UNICEF and the World Health

Organization (WHO). In order to receive this designation, SFGH will need to fully implement the following ten steps:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within an hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from the infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice "rooming in" by allowing mothers and infants to remain together 24-hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats, pacifiers, dummies, or soothers to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birthing center.

To demonstrate that we have successfully achieved the above ten steps and are continually in compliance, measures associated to the ten steps and monitoring plans will need to be developed. For this reason, the Breastfeeding Task Force will be reconvened in August 2000.

A press release of our intent to become a "Baby-Friendly Hospital" will be issued in the upcoming weeks.

DIVERSION

San Francisco General Hospital experienced 16 episodes of critical care diversion for a total of 107 hours and 45 minutes. This represents a total percentage of 15 % for June 2000. While SFGH was on critical care diversion, the Emergency Medical Services Agency suspended critical care diversion in the city of San Francisco on June 9, June 11, June 19, June 20, June 21 and June 24.

The Emergency Department recorded 34 episodes of total diversion for 154 hours and 30 minutes. This represents 21.5 % in June 2000. This is a decrease of 8.5 % from May. The ED was impacted to capacity during the episodes of total diversion.

The Emergency Department recorded six episodes of trauma override for a total of 22 hours and 50 minutes or 3% for June 2000. This shows a 2.7 % increase in trauma override in June. While on critical care diversion, the ED initiated trauma override on June 21 and June 24.

5) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES (Ken Jensen, Chief Financial Officer, CHN)

Ken Jensen presented the May Revenue and Expense Summary, (Attachment A).

Monique Zmuda, Chief Financial Officer, stated that she will present to the full Commission in August the year-end report for FY 1999-00. SFGH projects an additional \$3 million deficit due to revenue loss.

- 6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL

None.

- 7) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION

None.

Action Taken: The Committee voted to go into Closed Session.

The Committee went into Closed Session at 4:04 p.m.

- 8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION TAKEN: THE COMMITTEE APPROVED THE CLOSED SESSION MINUTES OF JUNE 11, 2000

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

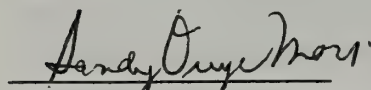
Individuals in the Closed Session were: Gene O'Connell, Ken Jensen, Alan Gelb, M.D., John Luce, M.D., Melissa Welch, M.D., Hiro Tokubo, Melinda Garcia, Connie Young, Monique Zmuda, Joseph Pendon, Alison Moed, Catherine Thurow, Diana Guevara and Sandy Mori.

- 9) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM)

Action Taken: The Committee voted not to disclose any discussion held in Closed Session.

The meeting was adjourned at 4:35 p.m.


Sandy Ouye Mori
Executive Secretary to
the Health Commission

Attachment (1)

**San Francisco General Hospital
Revenue & Expense Summary
May 2000**

The financial situation for San Francisco General Hospital as of the end of May, 2000 shows that the deficit is maintained at \$19.3 million. The additional revenue shortfall is attributed to the reduced census of sponsored patients.

Personnel services are below budget as vacancies and restrictions on the use of overtime and as-needed personnel continue.

Specifically:

- **REVENUE** is expected to be \$53.6 million <\$53.6M>
below expectations (11.7%), of which \$30 million
is due to a change in accounting for the net
revenue of SB1255 and GME instead of booking
gross revenue to include intergovernmental
transfer. There is a corresponding reduction in
operating expenses to reflect the omission of
intergovernmental transfer. Bad debt and
unreimbursed accounts explains the reduced
patient revenue of \$12.3 million, and SB855
(Disproportionate Share) reduction accounts for
\$10 million, as a result of further erosion of the
DSH pool. Other factors include \$2.3 million
reduction of capitation IHSS revenue, \$2 million
shortfall of Short Doyle payments, offset by
\$2 million increase in GME revenue and \$1 million
increase in Realignment revenue.

- **EXPENSES** are expected to be \$34.3 million \$34.3M
(7.5%) better than expected. The exclusion of
SB1255 & GME intergovernmental transfers
account for \$30 million; materials and
services are \$3.8 million better than budget;
and IHSS expenditures are \$1.6 million lower
than expected, salaries are \$1.3 million better
than budget. It should be noted that "non-
controllable" employee benefits are expected
to be \$2.4 million over budget.

Net Variance (4.2%)

<\$19.3M>
=====

• **STATISTICS**

YTD - Net Revenue/adjusted patient day	\$1,328
Cost/adjusted patient day	\$1,419
FTEs (incl. UC)/adjusted occupied bed	4.9
YTD Average Daily Census - total	430
- excl. MHRF	299

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)



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John I. Umekubo, M.D.
Vice President

Edward A. Chow, M.D.
Commissioner

Ron Hill
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
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David J. Sanchez, Jr., Ph.D.
Commissioner

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HEALTH COMMISSION
CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Sandy Ouye Mori
Executive Secretary

TEL: (415) 554-2666

FAX: (415) 554-2665

Website: <http://www.dph.sf.ca.us>

PUBLIC MEETING NOTICE

FOR

HEALTH COMMISSION COMMITTEES

JOINT CONFERENCE COMMITTEE FOR LAGUNA HONDA HOSPITAL

The meeting on Monday, July 10, 2000 has been rescheduled for:

*Monday, July 24, 2000
9:30 a.m. to 11:30 a.m.
Laguna Honda Hospital
375 Laguna Honda Blvd.
Conference Room B102*

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*The meeting for Monday, August 14, 2000 has been canceled.
No meeting in August.*

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL

*The meeting for Tuesday, August 8, 2000 has been canceled.
No meeting in August.*

JOINT CONFERENCE COMMITTEE FOR COMMUNITY HEALTH NETWORK

*The meeting for Tuesday, June 27, 2000 has been canceled.
No meeting in June.*

Posted June 19, 2000

San Francisco, CA 94102-4505

Roma P. Guy, M.S.W.
President

John L. Umekubo, M.D.
Vice President

Edward A. Chow, M.D.
Commissioner

Ron Hill
Commissioner

Lee Ann Monfredini
Commissioner

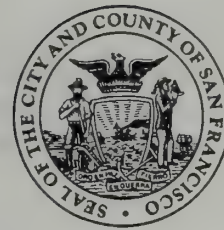
Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, September 12, 2000
3:30 - 5:30 p.m.
1001 Potrero Street, Room #2A6
San Francisco, CA 94110

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Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.

- 1) **CALL TO ORDER**
- 2) **FOR APPROVAL:** **MINUTES OF JULY 11, 2000 JCC-SFGH MEETING**
- 3) **FOR DISCUSSION:** **HOSPITAL HEALTHCARE UPDATE**
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
- 4) **FOR DISCUSSION:** **PATIENT CARE REPORT**
(Joseph Pendon, RN, MSN, Acting Chief Nursing Office)
**Report*

- 5) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Ken Jensen, Chief Financial Officer, CHN)
**Report*
- 6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**
- 7) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION
- 8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF JULY 11, 2000

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

9) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM)

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

Disability Access:

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines *#9 San Bruno*, *#9X San Bruno Express*, *#19 Polk* (stops 2 blocks away), *#33 Haight Ashbury*, and *#48 Quintara*. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine

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MINUTES

**JOINT CONFERENCE COMMITTEE MEETING
FOR
SAN FRANCISCO GENERAL HOSPITAL**

**Tuesday, September 12, 2000
3:30 p.m.**

**1001 Potrero Avenue, Room #2A6
San Francisco, CA 94110**

1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Chairperson, Commissioner Lee Ann Monfredini, at 3:35 p.m.

Present: Commissioner Lee Ann Monfredini

Absent: Commissioner Edward A. Chow, M.D.

DPH Staff: Gene O'Connell, John Luce, M.D., Ken Jensen, Beth Maloney, Kimberly O'Kane, Monique Zmuda, Joseph Pendon, Hiro Tokubo, Melinda Garcia, Alan Gelb, M.D.

Ms. O'Connell introduced new Medical Staff office employee Kimberly O'Kane, who came from St. Mary's Hospital.

2) APPROVAL OF MINUTES OF JULY 11, 2000

Action Taken: The Committee adopted the minutes of July 11, 2000.

3) HOSPITAL HEALTHCARE UPDATE

(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)

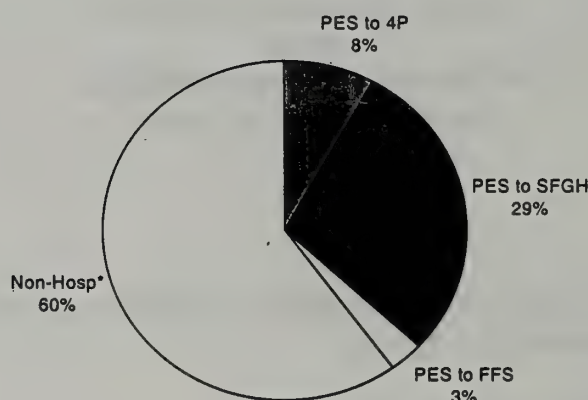
UPDATE ON STATUS OF PSYCHIATRY IN MEETING PERFORMANCE CRITERIA

For the past two months, Barbara Garcia and Gene O'Connell have been co-chairing a committee comprised of representatives from Community Mental Health Services (CMHS), Laguna Honda Hospital (LHH), Mental Health Rehabilitation Facility (MHRF), San Francisco General Hospital and Finance, to monitor the following:

Performance Measure #1

The rate of hospital admissions from Psychiatric Emergency Services (PES) at SFGH will stay at the current level (40% for Medi-Cal and indigent patients) or will decrease over the next year. This is measured by comparing the ratio (of hospital admissions to diversions to alternative services and program) on a monthly basis. (STATUS: From July 1st to August 22nd, the goal is met).

PES Dispositions* July 1 to August 22, 2000 (844 Episodes)



Performance Measure #2

The average length of stay of 15 days will be maintained throughout the year. This measure will exclude patients who remain hospitalized over 90 days when awaiting placement to locked skilled nursing facilities or Napa State Hospital. This measure also excludes patients in the hospital prior to July 1, 2000. (STATUS: From July 1st to August 31st, the goal is met).

<i>FUNDING SOURCE</i>	<i>LOS</i>	<i># OF DECERT. PATIENTS</i>	<i>AVERAGE LOS</i>	<i># DENIED DAYS</i>	<i># ADMIN DAYS</i>	<i>TOTAL # OF DECERTIFIED DAYS (Admin + Denied)</i>
<i>Medi-Cal</i>	<i>105</i>	<i>10</i>	<i>10.5</i>	<i>6</i>	<i>7</i>	<i>13</i>
<i>Medi-Medi</i>	<i>49</i>	<i>4</i>	<i>12.25</i>	<i>2</i>	<i>19</i>	<i>21</i>
<i>Short-Doyle</i>	<i>48</i>	<i>3</i>	<i>16</i>	<i>0</i>	<i>17</i>	<i>17</i>
TOTAL	202	17	11.88 (< 15 days)	8	43	51 days (25% of total 202 days)

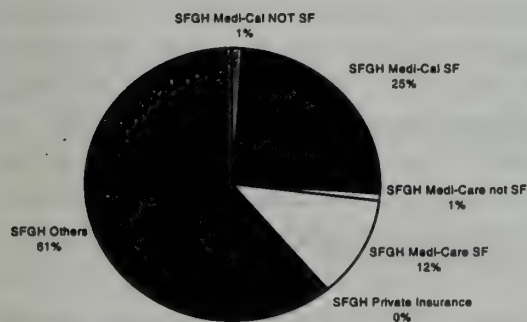
Performance Measure #3

Referral of patients to inpatient psychiatry beds will reflect the payor mix as assumed in the revenue budget and will maintain the use of SFGH as the safety net for all indigent patients. (STATUS: Goal has been met.)

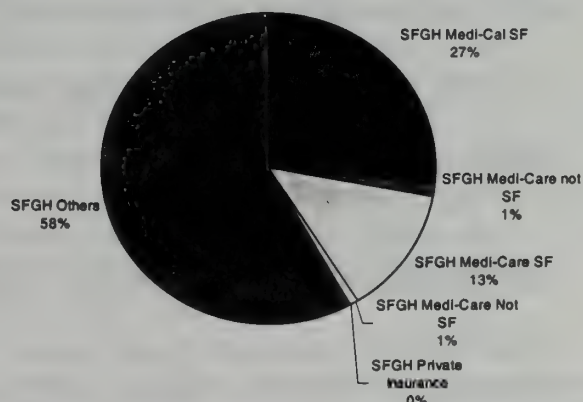
Performance Measure #4

PES and Inpatient Psychiatric Services will continue its policy of not admitting out-of-county Medi-Cal and Medicare patients to SFGH, as many of these patients are not reimbursed by the county of residence. (STATUS: from July 1st to August 31st, goal is NOT met). An Eligibility Worker will be assigned in October to focus on PES

**Funding Source of all SFGH Psychiatry Admissions
FY 1999-2000 (2242 episodes)**



**Funding Source for all SFGH Psychiatry Admissions
July and August, 2000 (407 episodes)**



In addition to monitoring the Performance Measures, the Committee is also problem solving patient flow and placement issues. A sub-committee was formed to look specifically at patient flow and placement between the San Francisco General Hospital (Medical-Surgical, Psychiatry, and SNF), the Mental Health Rehabilitation Facility, and Laguna Honda Hospital. The subcommittee has met as a whole once already, and in addition both Campuses (LHH & SFGHMC) have held their separate meetings to identify internal processes that could be improved to facilitate patient flow and placement.

MAMMOGRAPHY CQI TASK FORCE UPDATE

There are approximately 8,000 CHN patients (females over 40 who are regular primary care patients) who may represent the target population for annual mammography screenings. These patients reside primarily in the Mission, Excelsior, and Bayview Hunters Point areas of the City. Currently the CHN does about 4,000 annual mammograms (almost a 20% increase from FY 1997-98), reaching about half of the patients identified above. About 25% reside in the Mission, 14% in the Excelsior and 16% in Bayview and Visitation Valley; however, patients come from all over the City.

Currently, Radiology has two rooms where they perform approximately 16 screenings a day. Three days a week are used for diagnostic treatment and four days a week for screenings. Budget constraints, space constraints and staff shortages affect Radiology's ability to provide the number and kind of services that would be optimal. To help address this, the Task Force is pursuing options and recommendations on how CHN could best provide breast health services. Members of the Task Force have been meeting since mid July and include representatives from Radiology, Surgery, Oncology, Specialty Care, General Medicine, Family Practice, Community Primary Care, and Population Health and Prevention.

Current next steps for the Committee include:

- ◆ Continue brainstorming alternatives for providing services. Discuss pros and cons of each proposal. Recommendations are targeted for completion by November.
- ◆ Kevin Grumbach, Chief of Family and Community Medicine, will provide data on target number of patients using varying parameters.
- ◆ Gayling Gee will cost out staff and equipment for providing services at CHN.
- ◆ Diane Carr will investigate other models of care.

I will continue to update the JCC-SFGH as the mammography committee progresses.

ANNOUNCEMENT OF SUSAN CURRIN AS NEW CHIEF NURSING OFFICER

Ms. O'Connell announced the selection of a new Chief Nursing Officer for San Francisco General Hospital. After several rounds of interviews with numerous candidates, Susan Currin has been selected as the new Chief Nursing Officer position. During the past two years, Sue has been at Oakland Kaiser Permanente Hospital and Health Plan serving as the Quality and Service Leader for the East Bay Service Area. Sue has served in various nursing capacities during her 20-year career at San Francisco General Hospital. Sue will begin on October 6, 2000.

Ms. O'Connell thanked Joseph Pendon for all of his hard work in serving as the Interim Chief Nursing Officer. When Sue begins as the Chief Nursing Officer in October, Joseph will return to his role as the Director of Medical Surgical Nursing.

DEPARTURE OF ERIC MILLER, DIRECTOR OF FACILITY SERVICES

Mr. O'Connell announced that Eric Miller, Director of Facilities and Plant Services for the Department of Public Health will be leaving on September 15, 2000. Eric has served the Department of Public Health for 15 years in various capacities. He has accepted a position with Oakland Kaiser Permanente Hospital and Health Plan. San Francisco General Hospital will be hosting a farewell reception for him on Wednesday, September 13th from 4:00 -5:30 p.m. in the Main Cafeteria.

MENTAL HEALTH REHABILITATION FACILITY – RECIPIENT OF APNA'S BEST PRACTICES AWARD

The Mental Health Rehabilitation Facility Program has been selected to receive the American Psychiatric Nurses Association BEST PRACTICES AWARD for Best Treatment of Schizophrenia in an Inpatient Program.

Drs. Mozettia Henley, RN, DScN and Peggy Wilson, RN, DScN, submitted the proposal "Beyond Old Boundaries: A Nursing Model for the New Millennium," which was selected for the award. Dr. Henley serves as the Program Director of the Mental Health Rehabilitation Facility and Dr. Peggy Wilson is the Clinical Nurse Specialist for the Mental Health Rehabilitation Facility.

The award will be presented at the opening of the 14th Annual APNA Conference in Washington, D.C., on October 25, 2000.

4) PATIENT CARE REPORT (Joseph Pendon, RN, MSN, Acting Chief Nursing Office)

Bed Utilization Committee

In response to the continued high volume experienced by the Medical Center since mid-June, a Bed Utilization Committee consisting of Physicians and Registered Nurses, convened to focus on developing strategies to maximize patient flow and utilization of acute care beds. This Committee meets on a bimonthly basis. Examples of strategies identified by the Committee include:

a) detailed review of patients admitted to the various levels of care, and particularly those patients admitted to 4B Step Down, b) early identification and facilitation of patients to be discharged to the community or to skilled nursing systems, c) closer communication between discharge planners, utilization review, and the direct care providers, and d) piloting an Admission/Discharge Nurse to facilitate patient movement during peak movement hours of 1500-2100.

In addition to this Committee, the continued practice of meeting at 0730 with nursing representatives from the Emergency Department, Perioperative, Critical Care, Step Down, and Medical Surgical with Nursing Operations/AODs, to mutually develop detailed operational plans prioritizing and coordinating admission, transfers, and discharges occur. This proves to be an efficient mode of communicating the various needs of individual patients and respective units.

Voluntary Staff Reassignment

On July 24th, 2000 a letter was sent to the Inpatient Nursing Staff of SFGHMC advising them of the need to reduce staffing that was connected to the 20 medical surgical bed decrease proposed in the DPH's FY 00/01 budget. Attached to the letter were specific areas with targeted reduction as well as units with available positions. The letter encouraged staff to seek voluntary reassignment to areas of

interest, including those within their service line. The Nursing Staff received this letter from Administration in a very open and receptive manner. Within the time frame identified; staff voluntarily solicited opportunities in areas such as Health At Home, Jail Health Services, as well as specialties within the Inpatient areas, thereby, eliminating the need for mandatory involuntary assignments.

Diversion Statistics for July and August 2000

July 2000 Statistics

For July 2000, San Francisco General Hospital experienced 13 episodes of critical care diversion for a total of 212 hours and 20 minutes. This represents a total percentage of 28% for July 2000. This represents a 13% increase from June. As of August 1, 2000, critical care diversion is permanently suspended in San Francisco.

The Emergency Department recorded 47 episodes of total diversion for 231 hours and 20 minutes. This represents 31% for July. This is an increase of 9.5% from June. The ED was impacted to capacity during the episodes of total diversion.

The Emergency Department recorded four episodes of trauma override for a total of 18 hours and 10 minutes or 2.4% for June 2000. This shows a 0.6% decrease in trauma override in July.

August 2000 Statistics

In August, critical care diversion was indefinitely suspended in San Francisco. This is reflected in the total diversion and trauma override increases for the month.

The Emergency Department recorded 48 episodes of trauma override for a total of 67 hours and 10 minutes or 9% for August 2000. This is an increase of 11% from July. The ED was impacted to capacity during the episodes of total diversion.

The Emergency Department recorded 10 episodes of trauma override for a total of 67 hours and 10 minutes or 9% in August 2000. This shows a 6.6% increase in trauma override in August.

5) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES (Ken Jensen, Chief Financial Officer, CHN)

Mr. Jensen submitted the July Revenue and Expense Summary, (Attachment A).

Mr. Jensen reported that the annual audit for SFGH and Medicare audit are in progress. Medi-Cal is starting the 1999 audit.

Commissioner Monfredini suggested that the other Health Commissioners receive the latest information on decertified beds, the census, and diversion rates.

6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL

None.

7) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**

None.

The Committee went into closed session at 4:10 p.m. and came out of closed session at 4:35 p.m. Individuals in the Closed Session were the same as in the open session.

8) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

Action Taken: The Committee approved the closed session minutes of July 11, 2000.

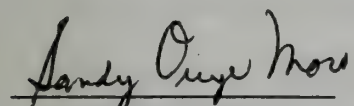
Consideration of Medical Audit, Quality of Care, Quality Assurance and Credentialing Matter

9) **RECONVENE IN OPEN SESSION**

Action Taken: The Committee voted not to disclose any discussions held in closed session.

The revisions to the SFGH Medical Staff Bylaws will be calendared for the October 3, 2000 Health Commission meeting. Copies of the revisions will be given to the Commissioners.

The meeting was adjourned at 4:40 p.m.



Sandy Ouye Mori
Executive Secretary to
the Health Commission

Attachment (1)

**COMMUNITY HEALTH NETWORK OF SAN FRANCISCO
SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER**

**Revenue and Expense Summary
July 2000**

The financial report for San Francisco General Hospital at July 31, 2000 projected a potential deficit of \$0.3M for the 00/01 fiscal year. The projection is based on the assumption that the SFGH outpatient pharmacy and business office initiatives have a five-month delay in implementation. The risk areas are highlighted as below:

- **San Francisco General Hospital** **Surplus/(Deficit)**
<\$0.3 M>
Operating revenue is projected to be \$780K better than budget based on the July census and payor mix. The risk of the deficit lies with the delayed implementation of the pharmacy and business office initiatives. As a result, the forecast points to a potential overspending in salaries and pharmaceuticals expenses of \$3.6M with a corresponding offset of reduced spending of \$2.7M in contractual services. The net overspending of expenditures is estimated at \$960K. Non-operating revenue reflects slightly lower cafeteria revenue of \$160K than budgeted.

- **SFGHMC STATISTICS** **July 2000**

YTD – Net Revenue/adjusted patient day (excl. GF)	\$1,280
Cost/adjusted patient day (excl. IGT)	\$1,428
FTEs (incl. UC)/adjusted occupied bed	4.8
YTD Average Daily Census – total	448
- excl. MHRF	316

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES
ONE MONTH ENDING JULY 31, 2000
(In Thousands of Dollars)

	YEAR-TO-DATE					ANNUAL				
	Actual	Budget	Fav/(Unfav)		Prior Year	Projection	Budget	Fav/(Unfav)		Prior Year
			Variance	% Var				Variance	% Var	
GROSS PATIENT REVENUE:										
Inpatient Medi-Cal Revenue	14,358	13,837	522	3.8%	13,491	163,441	162,920	522	0.3%	150,619
Outpatient Medi-Cal Revenue	3,845	4,324	(479)	-11.1%	3,790	50,431	50,910	(479)	-0.9%	47,210
Inpatient Medicare Revenue	5,613	4,751	862	18.1%	4,129	56,800	55,938	862	1.5%	54,766
Outpatient Medicare Revenue	1,597	1,897	(299)	-15.8%	1,732	22,035	22,333	(298)	-1.3%	21,725
Inpatient Other Revenue	7,166	6,908	258	3.7%	6,205	81,597	81,340	258	0.3%	83,296
Outpatient Other Revenue	4,877	4,931	(54)	-1.1%	4,860	58,000	58,054	(54)	-0.1%	59,350
TOTAL PATIENT SERVICE REVENUE	37,456	36,648	809	2.2%	34,207	432,304	431,495	810	0.2%	416,965
REVENUE DEDUCTIONS:										
Charity Care	4,492	5,945	1,453	24.4%	5,409	68,546	70,000	(1,453)	-2.1%	57,268
Provision for Medi-Cal Adjustments	13,616	12,737	(879)	-6.9%	11,683	159,976	149,972	10,004	6.7%	148,100
Provision for Medicare Adjustments	2,588	2,378	(210)	-8.8%	1,625	28,302	28,000	302	1.1%	28,480
Provision for Other Adjustments	4,841	4,116	(725)	-17.6%	2,542	39,642	48,463	(8,821)	-18.2%	53,287
Provision for Bad Debt	1,917	1,917	(0)	0.0%	1,412	23,000	23,000	0	0.0%	22,240
TOTAL REVENUE DEDUCTIONS	27,454	27,093	(361)	-1.3%	22,670	319,466	319,434	32	0.0%	309,375
NET PATIENT SERVICE REVENUE	10,002	9,554	448	4.7%	11,537	112,838	112,060	778	0.7%	107,590
OTHER OPERATING REVENUE:										
Capitation	663	663	0	0.0%	436	7,959	7,959	0	0.0%	6,279
Short Doyle	308	308	0	0.0%	511	3,694	3,694	0	0.0%	3,700
MHRF Funding	704	704	0	0.0%	704	8,453	8,453	0	0.0%	8,453
S8855	10,626	10,626	0	0.0%	11,460	127,518	127,518	0	0.0%	91,320
S81255	1,808	1,808	0	0.0%	3,500	21,700	21,700	0	0.0%	21,700
GME	108	108	0	0.0%	708	1,300	1,300	0	0.0%	1,300
Prior Year Settlement	4	0	4	#DIV/0!	0	4	0	4	#DIV/0!	83
MAA & Other Net Patient Revenue	292	292	0	0.0%	793	3,500	3,500	0	0.0%	5,852
OTHER OPERATING REVENUE	14,514	14,510	4	0.0%	18,112	174,127	174,124	4	0.0%	138,687
TOTAL OPERATING REVENUE	24,516	24,065	452	1.9%	29,649	286,966	286,184	782	0.3%	246,277
OPERATING EXPENSES:										
Personnel Services	12,236	12,456	220	1.8%	12,398	152,849	151,158	(1,691)	-1.1%	148,922
Mandatory Fringe Benefits	2,942	2,842	(99)	-3.5%	2,800	34,827	34,490	(337)	-1.0%	35,703
Contractual Services	7,724	7,949	225	2.8%	7,457	92,687	95,386	2,698	2.8%	91,257
Materials and Supplies (Excl. Pharmaceuticals)	2,087	2,080	(7)	-0.3%	2,094	24,993	24,960	(33)	-0.1%	23,420
Pharmaceuticals	1,220	1,000	(220)	-22.0%	1,625	13,594	12,000	(1,594)	-13.3%	14,968
Facilities Maint. & Capital Outlay	305	305	0	0.0%	2,207	3,664	3,664	0	0.0%	2,646
Services of Other Departments	1,211	1,211	0	0.0%	1,319	14,538	14,538	0	0.0%	13,377
Expenditure Recovery	(910)	(910)	0	0.0%	(863)	(10,923)	(10,923)	0	0.0%	(11,132)
Operating Transfer Out	8,185	8,185	0	0.0%	8,185	98,225	98,225	0	0.0%	62,164
Intrafund Transfer	187	187	0	0.0%	133	2,248	2,248	0	0.0%	1,590
Projects	336	336	0	0.0%	2,500	4,030	4,030	0	0.0%	4,123
TOTAL OPERATING EXPENSES	35,523	35,642	119	0.3%	39,855	430,733	429,776	(956)	-0.2%	387,038
OPERATING INCOME/(LOSS)	(11,007)	(11,578)	571	-4.9%	(10,206)	(143,767)	(143,592)	(175)	0.1%	(140,761)
NON-OPERATING REVENUE:										
General Fund	5,925	5,925	0	0.0%	3,055	71,104	71,104	0	0.0%	54,839
Realignment	5,093	5,093	0	0.0%	4,734	61,113	61,113	0	0.0%	57,813
Transfer In	517	517	0	0.0%	1,252	6,204	6,204	0	0.0%	8,833
Carryforward	131	131	0	0.0%	0	1,567	1,567	0	0.0%	9,249
Cafeteria	73	87	(14)	-15.6%	87	877	1,039	(162)	-15.6%	877
Miscellaneous	214	214	0	0.0%	226	2,565	2,565	0	0.0%	2,900
NON-OPERATING REVENUE	11,952	11,966	(14)	-0.1%	9,354	143,430	143,592	(162)	-0.1%	134,511
NET INCOME/(LOSS)	946	388	557		(852)	(337)	(0)	(337)		(6,250)

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION
JULY, 2000

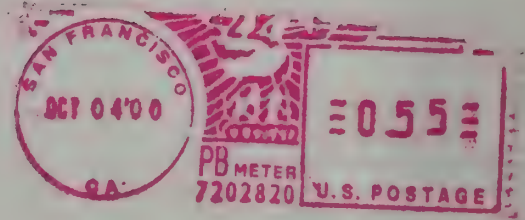
CURRENT MONTH

YEAR-TO-DATE

Actual	Budget	Variance	% Var	Prior Year	KEY VOLUME INDICATORS	Actual	Budget	Variance	% Var	Prior Year
1,539	1,653	(114)	-6.9%	1,653	Acute Activity	1,539	1,653	(114)	-6.9%	1,653
193	183	10	5.5%	197	Discharges	193	183	10	5.5%	197
103	97	6	6.3%	96	Average Daily Census	103	97	6	6.3%	96
20	19	1	5.4%	20	Acute Med/Surg ADC	20	19	1	5.4%	20
132	140	(8)	-5.8%	125	Psych ADC	132	140	(8)	-5.8%	125
448	439	9	2.1%	437	Skilled Nursing ADC	448	439	9	2.1%	437
7	7	0	3.7%	14	MHRF ADC	7	7	0	3.7%	14
11.0	10.0	(1.0)	-10.0%	6.4	Subtotal Adult ADC	11.0	10.0	1.0	10.0%	6.4
9.1	8.0	(1.1)	-13.8%	7.0	Nursery ADC	9.1	8.0	1.1	13.8%	7.0
9.3	8.0	(1.3)	-16.3%	6.4	Average Length of Stay	9.3	8.0	1.3	16.3%	6.4
					Medicare ALOS					
					Medi-Cal ALOS					
1,295	1,295	0.0	0.0%	1,327	Medicare Case Mix Index	1,295	1,295	0.0	0.0%	1,327
					Payor Mix (Gross Revenue)					
48.60%	49.56%	-0.96%		50.52%	Medi-Cal	48.60%	49.56%	-0.96%		50.52%
19.25%	18.14%	1.11%		17.13%	Medicare	19.25%	18.14%	1.11%		17.13%
32.15%	32.30%	-0.15%		32.35%	Other	32.15%	32.30%	-0.15%		32.35%
100.00%	100.00%	0.00%		100.00%		100.00%	100.00%	0.00%		100.00%
5,329	6,105	(776)	-12.7%	6,794	Patient Days	5,329	6,105	(776)	-12.7%	6,794
2,308	1,954	354	18.1%	1,844	Medi-Cal Patient Days	2,308	1,954	354	18.1%	1,844
6,236	5,302	934	17.6%	4,924	Medicare Patient Days	6,236	5,302	934	17.6%	4,924
13,873	13,361	512	3.8%	13,562	Other Patient Days	13,873	13,361	512	3.8%	13,562
19,148	19,205	(57)	-0.3%	19,472	Total Patient Days	19,148	19,205	(57)	-0.3%	19,472
83.3%	81.7%	1.7%	2.1%	81.5%	Adj. Patient Days	83.3%	81.7%	1.7%	2.1%	81.5%
111	101	10	9.9%	101	% Occupancy (available beds)	111	101	10	9.9%	101
					Deliveries					
2,287	2,296	9	0.4%	2,359	KEY OPERATIONAL INDICATORS	2,287	2,296	9	0.4%	2,359
333	313	(20)	-6.5%	326	Labor	333	313	(20)	-6.5%	326
2,621	2,610	(11)	-0.4%	2,685	FTEs - Productive	2,621	2,610	(11)	-0.4%	2,685
334	334	0	0.1%	351	FTEs - Non-Productive	334	334	0	0.1%	351
2,955	2,944	(11)	-0.4%	3,036	FTEs - Total	2,955	2,944	(11)	-0.4%	3,036
4.8	4.8	(0.0)	-0.7%	4.8	UC Non-Academic FTEs	4.7	4.8	0.1	1.2%	4.8
218.5	194.6	(24.0)	-12.3%	201.8	Total FTEs	218.5	194.6	(24.0)	-12.3%	201.8
58,568	57,442	(1,126)	-2.0%	57,059	FTEs Per AOB (incl. UC)	58,568	57,442	(1,126)	-2.0%	57,059
24.04%	22.8%	-1.22%	-5.4%	22.58%	Hours per adj. Acute Discharge	24.04%	22.8%	-1.22%	-5.4%	22.58%
332	227	105	46.2%	254	Labor Cost per FTE	332	227	105	46.2%	254
					Fringe Benefits as % of Salary					
					Vacancy positions					
1,280	1,253	27	2.2%	2,003	Revenues	1,280	1,253	27	2.2%	2,003
625	600	25	4.2%	568	Oper. Revenue per adj. Pat. Day	625	600	25	4.2%	568
11,541	10,128	1,413	14.0%	16,434	Oper. Rev. (excl. S8855/1255/GME)/APD	11,541	10,128	1,413	14.0%	16,434
5,637	4,849	788	16.2%	5,891	Oper. Revenue per adj. Discharge	5,637	4,849	788	16.2%	5,891
					Oper. Rev. (excl. S8855/1255/GME)/adj. Discharge					
1,855	1,856	1	0.0%	2,047	Expenses	1,855	1,856	1	0.0%	2,047
1,428	1,430	2	0.1%	1,498	Operating Exp. Per adj. Pat. Day	1,428	1,430	2	0.1%	1,498
16,723	15,001	(1,722)	-11.5%	16,793	Operating Exp.(excl. IGT)/adj. Pat. Day	16,723	15,001	(1,722)	-11.5%	16,793
12,869	11,556	(1,314)	-11.4%	12,290	Operating Exp. Per adj. Discharge	12,869	11,556	(1,314)	-11.4%	12,290
33%	32%	-1%	-2.5%	32%	Operating Exp.(excl. IGT)/adj. Discharge	33%	32%	-1%	-2.5%	32%
					Supply Exp. as % of net Pt. Rev.					
125	120	(5)	-4.2%	122	Days Revenue in Accounts Receivable	125	120	(5)	-4.2%	122

City and County of San Francisco
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Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

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AGENDA

**JOINT CONFERENCE COMMITTEE
FOR**

SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, October 10, 2000

2:30 p.m.

1001 Potrero Street, Room #2A6

San Francisco, CA 94110

CLOSED SESSION ONLY

Commissioner Edward A. Chow, M.D.

- 1) **CALL TO ORDER**
- 2) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**
- 3) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

ACTION ITEM:

**TO APPROVE CLOSED SESSION MINUTES OF
SEPTEMBER 12, 2000**

**FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT,
QUALITY OF CARE, QUALITY ASSURANCE,
AND CREDENTIALING MATTERS**

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

4) RECONVENE IN OPEN SESSION

**VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS
HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE
CODE SECTION 67.12(a) (ACTION ITEM)**

Disability Access:

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

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Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the

people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web site at: **www.ci.sf.ca.us/bdsupvrs/sunshine**

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President

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Vice President

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, November 14, 2000

3:30 - 5:30 p.m.

1001 Potrero Street, Room #2A6
San Francisco, CA 94110

Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.

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1) CALL TO ORDER

2) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)

3) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
**Report*

- 4) **FOR DISCUSSION:** **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Ken Jensen, Chief Financial Officer, CHN)
**Report*
- 5) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL****
- 6) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**
- 7) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

ACTION ITEM: **TO APPROVE CLOSED SESSION MINUTES OF OCTOBER 10, 2000**

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS**

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

8) **RECONVENE IN OPEN SESSION**

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM)

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

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MINUTES

JOINT CONFERENCE COMMITTEE MEETING FOR SAN FRANCISCO GENERAL HOSPITAL

Tuesday, November 14, 2000
3:30 p.m.

1001 Potrero Avenue, Room #2A6
San Francisco, CA 94110

1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Chairperson Commissioner Lee Ann Monfredini at 3:35 p.m.

Present: Commissioner Lee Ann Monfredini
Commissioner Edward A. Chow, M.D.

CHN Staff: Gene O'Connell, Phil Hopewell, M.D., Ken Jensen, Connie Young, Alison Moed, Tony Wagner, Monique Zmuda, Beth Maloney, Melissa Garcia, Carlos Villalva, John Luce, M.D., Alan Gelb, M.D., Hiro Tokubo, Sue Currin

2) HOSPITAL HEALTHCARE UPDATE

(Activities and operations of SFGH)

(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)

Update on Mammography Task Force

In June 2000, a mammography services task force was charged to explore and recommend ways in which to improve mammography services delivery SFGH patients. After meeting for four months, the Task Force drafted the proposal, which is available in the Commission Office.

On December 5th, 2000, the Year 2000 San Francisco General Hospital Medical Center Annual Report will be presented to the Health Commission. The Annual Report (draft available in the Commission Office) contains pertinent information regarding SFGHMC's performance in various areas through the reporting of staff competency, medical staff credentialing and bylaws, Hospital Plan for Provision of Patient Care, the Environment of Care, Utilization Review Report, Quality Management Report, and the Risk Management Report. All of these reports are presented to the Health Commission in accordance with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, specifically Governance Standard, GO.2, *"Those responsible for governance establish policy, promote performance improvement, and provide for organizational management and planning"* as well as various standards under "Leadership."

In preparation for the December 5th presentation of the Annual Report, Ms. O'Connell highlighted different points/items of each report. Overall, the content matter of each report has not changed significantly from those reports presented in previous years.

Competency

This report concentrates on the performance of all 2500 staff (both City and County and UCSF) who work at San Francisco General Hospital Medical Center. SFGH is currently still in the process of analyzing all performance appraisals for completeness and is continuing to input all performance appraisals into our database. The report will be completed by and presented to the Health Commission on December 5th. The initial results show that there are no significant changes in the distribution of the ratings and/or the identified problem areas of employees' performance as from what was presented the previous year.

Hospital Plan for Provision of Patient Care

The policy and procedure on the Hospital Plan for Provision of Patient Care was reformatted so to streamline the previous policy and procedure as well as more clearly address JCAHO and Title 22 guidelines. Changes seen in this revised plan include:

Section II: Authority and Responsibility

- Changing title from "Services provided at SFGHMC" to "Authority and Responsibility"
- Adding, "The responsibility for maintaining the quality of care is delegated to the SFGHMC Executive Administrator."
- Enumerating roles and responsibilities of:
 - SFGHMC Executive Committee
 - Medical Executive Committee
 - Directors, Chairpersons and Managers
 - Chief Nursing Officer

Section III: Scope of Service

- The patient population demographics has been updated
- African American and Latinos account for 50% of the Hospital's patients
- All ethnic minorities account for 65% of the Hospital's patients
- Reimbursement
- Medi-Cal visits to the Clinics and Inpatient discharges have declined

- The percentage of MIA, sliding scale/patient pay has increased for both clinics and inpatient

Section IV: Definition of Patient Services, Patient Care, Patient Support

- This section was rewritten so to more clearly define patient services, patient care, and patient support

Section VII: Quality Improvement Activities

- This section was rewritten so to more clearly show accountability and responsibility of all SFGHMC departments in following the hospital's plan for continuous quality improvement, with a cross reference to policy and procedure 17.1: Quality Improvement Program.

Section IX: Patients' Rights and Responsibilities and Organizational Ethics

- This section was added so to better address different JCAHO and Title 22 standards. This section cross-references already existing policies and procedures.

Quality Improvement Program

The purpose of the Quality Improvement Program is to establish and maintain a systematic process to measure, assess, and improve patient care and the organizational functions, which support the delivery of the care.

As part of the policy and procedure, the governing body must approve the SFGHMC Quality Improvement Program policy and procedure. There have been no significant changes made in the policy and procedure of the Quality Improvement program as from presented in previous years.

Quality Management Report

The Quality Management Department is responsible for ensuring and maintaining the quality of care and services provided to patients and residents within San Francisco General Hospital Medical Center. As an ongoing effort to meet all regulatory standards, as well as improve quality of care at San Francisco General Hospital Medical Center, the Quality Management Department is continually engaging in numerous new projects. Below is a summary of this year's projects.

1. SFGH is voluntarily participating in the PEP-C (Patient's Evaluation of Performance in California) Patient Satisfaction Survey, which is a statewide project sponsored by the California Institute for Health Systems Performance and the California HealthCare Foundation. Patients are asked to respond to questions about how well the hospital coordinated their care; are families involved with decision making; and are they given enough information when they are discharged.
2. With the suspension of Critical Care Diversion in the City, the Quality Management Department in collaboration with the Emergency Department will be monitoring the ED Diversion Rate and its impact on patient care.
3. In an effort to increase patient flow throughout San Francisco General Hospital, the Wound Care/ISIS Clinic was created. QM will be monitoring the program's effectiveness in improving patient flow and decreasing decertified days in Acute Medical-Surgical.

4. All Type I's were removed from the May 1999 JCAHO survey and in March 2000, SFGH finally received the CALS report from DHS. All plans of corrections were accepted by DHS.
5. Because of changes made by HCFA and JCAHO, a Task Force has been charged to develop an institution-wide response to updating restraint policies and practices and ensuring that staff receive appropriate training.

SFGH has also participated in the Finance Subcommittee's Work Group on Benchmarking. SFGH selected four benchmarks to monitor in FY 2000/01:

Access Benchmark

SFGH = ED diversion rate does not exceed a rate of 10%

Prim Care = New patient appointment available within 30 days

Customer Service Benchmark

SFGH = The overall rating (percent "excellent") will be within 3% of the PEP-C overall average.

Prim Care = Greater than or equal to 85% of respondents on FY00/01 patient satisfaction survey will rate their overall impression of the services as "excellent" or "very good".

Financial Benchmark

SFGH = Percentage decrease in decertified days for medical, surgical and inpatient psychiatric patients.

Prim Care = Reduce disallowed targeted case management claims by 10%. This measure will trace financial data for case management claims.

Health Benchmark

SFGH = Percentage decrease in inpatient admissions of soft-tissue/abscess patients.

Prim Care = Increase mammography screening rates by 10% by 7/1/2001.

Risk Management Report

The Risk Management Program is responsible for establishing a multidimensional, systematic, and comprehensive approach to the identification, evaluation and treatment of risks that could result in a loss. The goal of the Risk Management Program is to identify risks and coordinate risk reduction activities, with a focus on the development of broad-based action plans, which address systems issues. The Risk Management Program is housed within the CHN Quality Management Program. Over the year, the Risk Management Committee has identified and/or addressed general and specific areas of risks. All of the following were presented to the JCC for review:

- Emergency Department (ED) policy regarding service for 911 patient population;

- ED alcohol withdrawal management guidelines;
- Revision of perinatal services visiting policy;
- Standardization of patient assessment, monitoring and discharge tools on all Psychiatry units;
- Psychiatry Department-wide approach to substance abuse treatment on the inpatient units;
- Formalization of ED medicine resident orientation;
- Clarification of standards related to Forensics/Psychiatry interfacility transfers;
- Formalized system between Psychiatry and Community Mental Health Services to identify and review high-risk clients;
- Revision of pertinent ambulatory care procedures to ensure EMTALA compliance;
- Improvement of system-wide communication regarding high-risk obstetrical patients;
- Educational in-services, including Nursing assessment and care of the trauma patient, documentation, utilization of the physician chain command, notification of the primary care provider, communication between services (OB/GYN, Pediatrics, Nursing)

Risk Management also oversees the handling of claims and coordinates defense preparation involving SFGH staff, including the management of requests from the Office of the city Attorney for the presentation of physical evidence, production of documents, preparation of interrogatories, and arrangement of court appearances and depositions. For the fiscal year of 1999-2000, Risk Management received a total of 100 claims. Since the closure of the fiscal year 1999-2000, all 100 of the investigations linked to the claims have been closed. The number of claims and the nature of the claims received during fiscal year 1999-2000 do not significantly differ from those received in fiscal year 1998-1999.

Medical Staff Report

The Medical Staff Report highlights activities of the Medical Staff over the course of the last fiscal year (99-00). The following are all events, which will be discussed in the report:

- The Annual Meeting of the SFGH Medical Staff was held on June 7, 2000, with approximately 200 physicians and guests in attendance. The Honorable Willie L. Brown, Mayor of San Francisco was the guest speaker. Hideyo Minagi, MD was presented with the Eliot Rappaport Award for his long-term commitment and dedication to humanist care of patients at SFGH, his leadership and distinguished accomplishments in the clinical teaching program in the Department of Radiology.
- Jerolyn (Renee) Navarro, MD, Department of Anesthesia, was elected Chief of Staff, Elect. Her term as Chief of Staff will begin July 1, 2001.
- On January 3, 2000, Hiroshi Tokubo, MD, joined the CHN Leadership team as CHN Director of Quality Management.
- On May 1, 2000, Elizabeth Maloney joined the CHN Medical Staff Services Department as its new director.
- The SFGH Medical Staff Bylaws, Rules, and Regulations were amended and ratified by the Health Commission October 3, 2000.
- The current number of Medical Staff members is 992. There are currently 140 Professional Affiliated Staff members. Currently, there are 85 Medical Staff applications in process.
- During the fiscal year, 212 new appointments to the Medical Staff were approved and 414 reappointments were approved.

- The Medical Staff Leadership has encouraged physician participation in the interdisciplinary performance and quality improvement clinical initiatives.
- In compliance with external regulatory agencies, the Credentials Committee, in conjunction with the Quality and Risk Management Committees, is reviewing clinical criteria developed by the Clinical Service Chiefs for appointment and reappointment of physicians to the Medical Staff.

Utilization Management Report

The purpose of the Utilization Review Plan is to achieve effective allocation of inpatient resources, which promote effectiveness and cost efficient medical care. Issues and solutions to problems are identified through the process of conducting and reporting utilization findings. Due to the different standards that portions of SFGHMC are accountable for (i.e. Long-Term Care, Behavioral Care, and Acute Care), specific utilization review plans have been created for specifically Acute Medical-Surgical, Mental Health Rehabilitation Facility, and both Acute Psychiatry and Outpatient Psychiatry.

In all reports, the only significant change has been made in the Acute Medical-Surgical Utilization Review Plan. The definition of the Utilization Review Nurse was strengthened so to demonstrate their involvement as a case manager in trying to increase patient flow throughout the campus.

Environment of Care Mid-Year Update

The purpose of the environment of care report is to address the SFGHMC management plans for the areas of:

- Emergency Preparedness
- Hazardous Materials
- Life Safety
- Medical Equipment
- Safety
- Security
- Utility Management
- Infection Control

The Environment of Care (EOC) report was last reported to you in March 2000 and therefore the annual report will be presented to you in March 2001. This report will provide you an update status on where we are in meeting our EOC goals.

In an effort to more easily identify policies and procedures (P&Ps) that address the Environment of Care (EOC), the SFGHMC Executive Committee approved the Environment of Care Committee's request to separate out these P&Ps into a separate binder for just P&Ps concerning EOC. All of these P&Ps would continue to be reviewed by the SFGHMC Executive Committee. This is also the first year that Infection Control has been incorporated into the EOC report. In the previous years, Infection Control issues were reported through the QUM report. Infection Control issues continue to be reported into the Quality Utilization Management Committee.

San Francisco General Hospital Medical Center is progressing forward towards meeting all of year 2000 goals in all areas, with additional accomplishments in the following areas:

Emergency Preparedness

- National Disaster Medical Conference presentation
- Participation in the following drills and exercises: SFUSD drill 5/00, SFPD exercise 6/00, SFPD exercise 7/00, Golden Gate Bridge Response exercise 7/00
- Development of HAM radio system at SFGH

Life Safety

- All scheduled testing, maintenance and inspection were accomplished
- All required drills were completed with an increase in site specific training

Medical Equipment

- Ongoing maintenance records indicate compliance to standards above 90%.

For this fiscal year, SFGH has had incidents in the following areas:

Life Safety

- Interim life safety concerns are minimized due to major reduction in both large-scale maintenance and construction – No incidents reported thus far in 2000
- Recent fire incidents have been reported in 2000. This is an increase from 1999, which had no reported incidents. Review of these incidents is ongoing.

Utility Management

- Two power failures have occurred so far in 2000, systems operated effectively.

Commissioner Monfredini suggested each of the other Commissioners be given the opportunity for a briefing of the Annual Report and the U.C. Affiliation Agreement.

Commissioner Monfredini commented that SFGH is not the sole hospital serving the uninsured and indigent and that the other hospitals in the City also have responsibility. She suggested closing down SFGH so that the other hospitals would have to do more for the indigent and underinsured.

Carlos Villalva, Office of Architecture and Facility Planning, gave a progress report for a Master Plan to meet seismic safety standards under SB 1953. He reported that the consultant's work on the seismic safety evaluation is to be completed by January 2001. He presented the Facility Planning Options for SFGH as related to the Seismic Safety Mandates. The Commissioners requested a copy of the consultant's report.

3) **PATIENT CARE REPORT** (Sue Currin, RN, Chief Nursing Office)

Miss Currin presented her report (Attachment A) and the Diversion Report for October. The Diversion Report is available in the Commission Office.

4) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Ken Jensen, Chief Financial Officer, CHN)

Mr. Jensen presented the 3-month statement of revenue/expenses ending September 30, 2000, and the Summary of Statistical Information (Attachment B).

Mr. Jensen reported that the Mayor's Office has authorized a \$1.5 million supplemental for neurological equipment at San Francisco General Hospital. This amount will come out of next year's budget.

5) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**

None.

6) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**

None.

The Committee went into Closed Session at 5:50 p.m. The persons in the Closed Session were the same except for Carlos Villalva.

7) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

ACTION TAKEN: THE COMMITTEE APPROVED THE CLOSED SESSION MINUTES OF OCTOBER 10, 2000

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

The Committee came out of Closed Session at 6:14 p.m.

8) **RECONVENE IN OPEN SESSION**

ACTION TAKEN: THE COMMITTEE VOTED NOT TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a))

The meeting was adjourned at 6:15 p.m.

Sandy Ouye Mori
Executive Secretary to
the Health Commission

Attachments (2)

Roma P. Guy, M.S.W.
President

John L. Umekubo, M.D.
Vice President

Edward A. Chow, M.D.
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Sandy Ouye Mori
Executive Secretary

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, January 30, 2001
12 noon - 2:00 p.m.
101 Grove Street, Room #302
San Francisco, CA 94102

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JAN 31 2001

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Commissioner Lee Ann Monfredini, Chairperson
Commissioner Edward A. Chow, M.D.

- 1) CALL TO ORDER
- 2) PROPOSED ACTION: CONSIDERATION OF APPROVING THE MINUTES
FOR NOVEMBER 14, 2000
*Minutes
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
*Report

- 5) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Ken Jensen, Chief Financial Officer, CHN)
**Report*
- 6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**
- 7) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION
- 8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF NOVEMBER 14, 2000

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

9) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM)

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

Disability Access:

Room 300, 101 Grove Street is wheelchair accessible through the Grove Street entrance.

American sign language interpreters and readers are available with advance notice of three business days. The Department of Public Health will make every effort to accommodate requests for sound enhancement systems and alternative formats for meeting minutes and agendas. Please

make these requests as far in advance as possible. For all requests contact Mariana Valdez at the Department of Public Health, Equal Employment Opportunity Program, telephone 554-2595. Late requests will be honored if possible.

In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City to accommodate these individuals.

For the 101 Grove Street meeting, the closest accessible station for Muni and BART is the Civic Center station. For information about MUNI services, call 673-6864. Accessible parking is located at the southwest corner of Grove and Polk Streets.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room #244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna-Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us.

Roma P. Guy, M.S.W.
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Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
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David J. Sánchez, Jr., Ph.D.
Commissioner

John L. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, February 13, 2001
3:30 pm – 5:30 p.m.
San Francisco General Hospital
1001 Potrero, Rm. 2A6 Conference Room
San Francisco, CA 94110

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Commissioner Lee Ann Monfredini, Chairperson
Commissioner John Umekubo, M.D.

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: CONSIDERATION OF APPROVING THE MINUTES
FOR January 30, 2001
**Minutes*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
- 4) FOR DISCUSSION: UPDATE ON THE SFGH REBUILD PLANNING
COMMITTEE

- 5) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
**Report*
- 6) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES
AND EXPENDITURES
(Ken Jensen, Chief Financial Officer, CHN)
**Report*
- 7) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT
MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN
FRANCISCO GENERAL HOSPITAL**
- 8) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED
SESSION
- 9) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b);
1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA
CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF
January 30, 2001

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT,
QUALITY OF CARE, QUALITY ASSURANCE, AND
CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

10) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL
DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO
ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM)

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

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Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

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City and County of San Francisco
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Department of Public Health
101 Grove Street, Room #311
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MINUTES

JOINT CONFERENCE COMMITTEE MEETING FOR SAN FRANCISCO GENERAL HOSPITAL

Tuesday, February 13, 2001
3:30 noon
1001 Potrero Avenue, Room #2A6
San Francisco, CA 94102

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1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Chairperson Commissioner Lee Ann Monfredini at 3:35 p.m.

Present: Commissioner Lee Ann Monfredini
Commissioner John I. Umekubo, M.D.

CHN Staff: Gene O'Connell, Tony Wagner, Ken Jensen, Hiro Tokubo, Fanny Lee, Connie Young, Alison Moed, Carlos Villalva, Alan Gelb, M.D., Melissa Welch, M.D., Melinda Garcia, Monique Zmuda, Cathryn Thurow, Yuhum Digdigan

Commissioner Monfredini announced that the JCC-SFGH meeting will be from 3:45 p.m. to 5:30 p.m.

2) APPROVAL OF MINUTES OF THE JCC-SFGH MEETING OF JANUARY 30, 2001.

Action Taken: The Committee adopted the minutes of January 30, 2001.

3) HOSPITAL HEALTHCARE UPDATE (Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)

SECURITY UPDATE

With the increase of gang violence in the community, security at SFGH has been increased to better ensure the safety of San Francisco General Hospital's patients, staff, visitors and surrounding community. Changes in security include:

- ◆ 24-hour security presence in the lobby as well as increased security presence around the clock
- ◆ Stricter enforcement of visiting hours – Visiting hours of 11:00 a.m. to 8:00 p.m. are being more strictly enforced. After 8:00 p.m., visitors may only enter SFGH through the Main Lobby. All other entrances to the building, with the exception of the Emergency Department, are locked down. Visiting passes are issued by Institutional Police stationed in the lobby who consult with Nurse Managers for authorization of issuing the visitor passes. End of visiting hours is announced over the overhead speakers at 7:55 p.m. Security rounds each unit to make sure that visitors who have not been authorized to visit patients past 8:00 p.m. have left the building by 8:00 p.m.
- ◆ Liaison with City and County of San Francisco (CCSF) Gang Task Force has been renewed so as to remain abreast of current activities in the neighborhoods.
- ◆ Increase of signage directing all to use the Main Lobby as the entrance to the hospital.

Long term plans to strengthen the security at San Francisco General Hospital includes utilizing key card entry systems. The project has already been initiated and the costs and time connected to the completion of the system is currently being investigated. The full implementation of the key card entry system would allow SFGH to more easily control and monitor the number of entry points into the hospital.

ANNOUNCEMENTS

Unannounced State Fire Marshall Visit

On February 9, 2001 the State Fire Marshall made an unannounced life safety survey visit on the 4A Skilled Nursing Facility Unit. During this short survey, the State Fire Marshall found the facility to be in compliance with all provisions of the Life Safety Code.

Paul Volberding to Accept New Position at the VA Medical Center

Paul Volberding, Director of the Positive Health Clinic, will be leaving to take a new appointment as the Chief of the Medical Service at the San Francisco Veterans Affairs Medical Center. A farewell reception will be held on February 22, 2001 at the SFGH Main Cafeteria from 3:00 p.m. to 5:00 p.m. to thank him for all his years of dedication to SFGH.

Ms. O'Connell reported a donation of \$356,000 was given by LeMar Hoaglin for AIDS research.

4) UPDATE ON THE SAN FRANCISCO GENERAL HOSPITAL REBUILD PLANNING COMMITTEE

Ms. O'Connell provided a status report, (Attachment A), on the SFGH Rebuild.

5) PATIENT CARE REPORT

(Yuhum Digdigan for Sue Currin, R.N., Chief Nursing Office)

Ms. Digdigan submitted the Patient Care Report, (Attachment B).

6) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Ken Jensen, Chief Financial Officer, CHN)

Mr. Jensen submitted the Statement of Revenue and Expenses and the Summary Statistical Information for January 2001, (Attachment C).

7) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**

None.

8) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**

None.

The Committee went into Closed Session at 4:40 p.m.

Individuals present in the Closed Session were the same as in the Open Session, except for Yuhum Digdigan.

9) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 14641; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

Action Taken: The Committee approved the Closed Session minutes of January 30, 2001

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CAARE, QUALITY ASSURANCE AND CREDENTIALING MATTERS

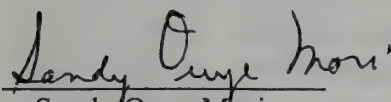
Alan Gelb, M.D., Chief of Staff, SFGHMC
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

The Committee came out of Closed Session at 4:55 p.m.

10) **RECONVENE IN OPEN SESSION**

Action Taken: The Committee voted not to disclose any discussions held in Closed Session.

The meeting was adjourned at 5:05 p.m.


Sandy Ouye Mori
Executive Secretary to
the Health Commission

Attachments (3)



Background

As you are aware, State legislation, SB 1953 (Alquist) and SB 1801 (Speier), requires that existing acute care hospitals in California either be seismically upgraded to progressively higher standards, or rebuilt, to minimize the risk to life and property in the event of a major earthquake. In order to comply with the regulations, San Francisco General Hospital (SFGH) must complete the construction of a new conforming acute care hospital by January 1, 2013. While the timeline is tight, getting a bond measure for this project on the November 2001 ballot will assist us in meeting the other legislative deadlines.

Several deadlines are driving the timetable for the SFGH rebuild. March 21, 2001 is the deadline for the submission of the Bond Report to the Capital Improvement Advisory Committee (CIAC). Following the submission to CIAC, the Bond Report is submitted to the Board of Supervisors. Board approval is needed by June 2001 to ensure that the Bond measure will be included on the November 2001 ballot. The master calendar (appendix 1) and the project timeline (appendix 2) can be found in your packet.

This is an exciting project. Rebuilding provides the opportunity for us to reconfigure services to maximize resources, increase efficiencies, and improve our system of care, which benefits all San Franciscans. Support for this project has been consistent. Staff and clinicians have been playing an integral role in the planning. Decisions about acute care will have an impact on every component of the Department of Public Health's delivery system.

Charge

Since the Health Commission approved its resolution supporting the rebuilding of San Francisco General Hospital acute care facility, a Planning Committee and three Subcommittees—Program, Finance, and Technical—have been meeting weekly (see appendix 3). The eighty members of these committees represent diverse groups -- prominent business, civic and community leaders, elected officials, clinicians and other health care professionals, labor unions, advocates, neighbors, community agencies and consumers of our services. The specific charge for each of these committees are:



Program Subcommittee

- Recommend what programs will be moved to the new acute care hospital/trauma center
- Recommend what size building is needed to accommodate these programs
- Recommend types of rooms (private vs. shared), types of nursing units, and support service needs
- Recommend how these programs should be configured in the new building and in relation to the existing main hospital building

Technical Subcommittee

- Establish character of physical implementation for a new acute hospital/trauma center at SFGH under the SB 1953/SB1801 provisions
- Outline principal planning guidelines for new/old facility
- Identify major building and licensing code parameters for the project
- Develop cost projections and timetable in conjunction with the Finance Subcommittee
- Articulate rationale for alternative options

Finance Subcommittee

- Establish total projected budget via public finance vehicles
- Identify limits of City capacity to fund this project
- Identify possible funding sources at state and federal levels
- Identify elements of the project that can/should be financed by alternate means
- Forecast implications to budget if project is delayed

Planning Committee

- Review the recommendations of the three Subcommittees to form a cohesive recommendation for the Health Commission to consider on February 28, 2001.

Status Report

Because there is a short turn-around time to meet our deadlines, all the Committees have been moving rapidly and meeting in parallel. Chairs of each of the Subcommittees— myself for Program, Ken Jensen, CHN CFO for Finance and Carlos Villalva for Technical have been attending each meeting to ensure timely communication. Since January, the Subcommittee's have met four times. The following report describes the work of the Subcommittees thus far:



Program Subcommittee

Planning Assumptions

The Program Subcommittee began its work with the following programmatic assumptions:

- SFGH will continue to maintain a Level One Trauma Center
- SFGH will continue to maintain its referral center role
- SFGH will continue to have an academic affiliation with UCSF
- SFGH will continue to serve as the City's primary provider for the indigent and incarcerated, however, these populations alone cannot support an acute hospital either financially or programmatically.
- Program planning will proceed based on current information and relationships, but must be flexible to future changes -- both patient need as well as plans that other hospital's put forward.

Required Programs

According to the legislation, the following SFGH programs are required to move into a new seismic conforming building: AIDS/Oncology Nursing, Cardiac Catheterization Laboratory, Clinical Laboratories, Critical Care Unity, Dietary, Emergency Services, GCRC, Inpatient Pharmacy, Intensive Care Unit, Jail Medical/Surgery Nursing, LDRP, Mechanical Spaces, Medical/Surgery Nursing, Non-Intensive Care Unit, OB/GYN Operating Rooms, Operating Rooms/PACU, Pediatrics, Radiology, Step Down, Sterile Supply, Sub-basement - Transformers, Trauma.

Discretionary Programs

The Program Subcommittee is also reviewing some programs that are not legislatively required to move, but from a programmatic or cost perspective may make sense to move into the new building. These programs include: Acute Psychiatry, Nuclear Medicine, Occupational/Speech Therapy, Oral Surgery, Psychiatric Emergency Services, Rehabilitation Services, Respiratory Care Services.

Programmatic Needs

Surveys were distributed to all the hospital services required to move to project future need (see appendix 4). Four focus groups: 1) peri-operative services, 2) ED/diagnostics, 3) pediatrics/obstetrics 4) psych/mental health -- have been assigned to come up with the details from each service about projected future need, configuration



of services, recommended adjacencies and size. A key issue will be how can the planning for the new acute hospital/trauma center remain flexible in order to accommodate future needs of the programs, which are currently unknown. I will keep you informed as recommendations are forthcoming.

Adjacencies

The Program Subcommittee has recommended that the new building be adjoined to the existing main hospital and that service adjacencies be configured to optimize staffing and operational efficiencies, and patient care. The Technical Subcommittee is currently reviewing the seismic, code and licensure issues that are triggered once the buildings are adjoined.

Antitrust Issues

In August 2000, the Bay Area Region of the Hospital Council prepared a briefing regarding hospital's ability to joint plan around SB 1953 requirements. It was their sense that joint planning, may result in anti-competitive effects, violating federal and state antitrust laws (Section 1 of the Sherman Act, 15 USC 1 and California's Cartwright Act, B & P Code Section 16700). Recently, the City Attorney has been consulted. It is their opinion that we would not violate antitrust regulations in regards to joint planning. I have begun to meet with UCSF to discuss the possibilities for planning together. Preliminary issues that have been raised include maintaining our ability to provide research space on the SFGH campus, joint OB/Peds programs and the future of UC psych programs. I will continue to update you on where these discussions are heading.

Technical Subcommittee

Site Issues

The Technical Subcommittee is preparing a study that will review three potential sites on the SFGH campus where the new Acute Care/Trauma Center may be built. The site now being favored is the B/C parking lot located alongside the main hospital building emergency entrance. It is estimated that the size will be approximately 350,000 square feet, with six stories and a basement. The size may ultimately change based on program recommendations and cost considerations.

The new Acute Care/Trauma Center's bulk must balance the height of the current main hospital building with the residential neighborhood located opposite SFGH on 23rd Street. This project site is 340 feet by 215 feet. The height limitation for the building is 105 feet.



Parking

Building the Acute Care/Trauma Center on the B/C parking lot will eliminate 157 existing public parking stalls. The precise number of parking stalls that will be required by code due to the addition of square footage on the campus is unknown at this time, however, 339 stalls can be added to the existing 811 stalls in the parking garage located between 23rd and 24th Streets.

Code Triggers

Pro-bono architects and engineers who are members of the Technical Subcommittee are currently reviewing the possibility of code issues that might be triggered at the main hospital building once the acute care medical services are relocated. I will continue to keep you informed on this issue.

Finance Subcommittee

Types of Funding

There are three types of bonds available to the city for general fund use. These include general obligation bonds (GOB), lease revenue bonds (LRB) and certificates of participation (COP).

GOBs are secured by monies received from property taxes, and therefore require a two-thirds vote. GOBs are limited by the City's debt capacity. The City's debt capacity is 3% of the assessed value of taxable real and personal property in the City. This assessed value is revised by the Assessor's office each August. The City's current debt is \$2.3b. There is \$930m outstanding and \$1b authorized but unissued. A GOB allows the City to raise funds without the need to reallocate dollars within the general fund. A GOB is considered the highest quality for investors and as such the interest rates are the lowest for long-term financing. GOBs can only be used for real property improvements.

Lease Revenue Bonds (LRB) are not debt pursuant to the state constitution. Because the asset to be financed is generally the collateral for the bonds, investors care significantly about the use of the bond proceeds. They are passed by a simple majority vote. A security deposit of up to one year's debt service must be placed in a reserve fund when funding comes through LRBs. LRBs require capitalized interest, which can be quite expensive. LRBs are legally secured by the general fund and there is no debt coverage.



It is recommended that funding for the Acute Care/Trauma Center be through General Obligation Bonds to go before the voters in November 2001. The Subcommittee is researching the possibility of using the existing parking bond authority to fund the required parking lot expansion. Expediting the parking expansion could result in significant savings. Revenue from the parking garage does not come to the hospital.

Movable Equipment

An inventory is being made of movable and fixed equipment. Funding sources alternative to the GO Bond will need to be identified for the movable equipment budget. Some equipment is purchased through the UC contract. It may be possible to finance movable furniture, fixtures, and equipment through Lease Revenue Bonds. In addition, the San Francisco General Hospital Foundation has been contacted regarding their involvement in funding for furniture, fixtures and equipment costs.

Site and Size Options

The Finance Subcommittee will identify cost estimates for various size and site options for the Acute Care/Trauma Center, and will provide an incremental step down analysis. It is suspected that the difference in savings due to alternative site and size options will not be significant. Though it is too early to determine set project costs, various scenarios will be explored. Flexibility is a priority for all models according to the need to accommodate future changes.



Alternative Funding Sources

Senator Diane Feinstein has introduced a bill that may provide funding for earthquake retrofitting and planning activities, but not bricks and mortar. The bill is not specific to hospitals, but rather is a general seismic bill. The Finance Subcommittee will continue to monitor state and federal legislation that would support hospital seismic safety upgrades.

Communication Plan

Target Populations

Communication plans (see appendix 5) have been established targeting the community, business and civic groups, SFGH neighbors, labor unions, state and federal congressional delegations, elected officials, advocates as well as internal DPH, SFGH and UCSF staff and faculty.

Communication Tools

The Internet website is up and running. All minutes and information pertaining to the SFGH Rebuild can be found at www.dph.sf.ca.us/SFGHRebuild. Letters have been sent to over 400 of SFGH neighbors in both English and Spanish languages (see appendix 6). A speakers bureau has been established and community town hall meetings are being arranged for many of the supervisorial districts of the City. One page frequently asked questions – *FAQs* are being drafted and a telephone information line has been set up at 206-2369.

An internal email has been set up for SFGH staff to get weekly updates give input and ask questions. Staff meetings are being arranged to keep staff informed on the progress of our planning and a bulletin board (outside 2nd floor cafeteria) will have weekly updates for staff to read.



PATIENT CARE REPORT

Joint Conference Committee- San Francisco General Hospital

February 13, 2001

Susan Currin, RN, MSN

Chief Nursing Officer

Patient Flow

In a continued effort to improve patient flow throughout San Francisco General Hospital as well as our continued commitment to place patients at the appropriate level of care, San Francisco General Hospital has been reporting patient flow data weekly at Mitchell Katz's Director's Cabinet meetings. The following is just a snap-shot of San Francisco General Hospital's patient flow for the week of February 5, 2001:

SFGH CURRENT CENSUS: 308

SFGH BUDGETED CENSUS: 292

- ♦ Med-Surgical = 184 (*budgeted 180*)
 - Critical care (4E & 5E) = 16 (*budgeted 18*)
 - 4B = 21 (*budgeted 21*)
- ♦ Psychiatry = 98 (*budgeted 92*)
- ♦ SNF= 26 (*budgeted 20*)

NUMBER OF PATIENTS WAITING FOR BEDS:

- ♦ ED 9
- ♦ PACU 1
- ♦ PES 4

Total: 14 Patients Waiting for Beds

DIVERSION STATUS IN JANUARY 2001:

Diversion Type	# Episodes	Hours	Percentage	Change from previous month
Total Diversion	49	280	38%	14% increase
Trauma Over-ride	10	44	6%	2% increase

NUMBER OF PATIENTS/RESIDENTS ACCUMULATING DECERTIFIED DAYS:

Medical-Surgical

- ♦ 9 Needs placement at LHH
 - 5 awaiting decision - initial
 - 1 accepted – no beds at LHH (waiting on 4A)
 - 1 accepted to LHH hospice– 2/01/01
 - 1 LHH requesting special contract and agreement for SFGH to take back patient if problems arise
 - 1 LHH requesting special behavioral contract. (waiting in 4A)
- ♦ 6 Needs 4A placement
 - 6 awaiting decision and/or bed availability
- ♦ 2 Needs community placement
 - 1 needs respite or hotel
 - 1 waiting on DPH Housing for appropriate placement
- ♦ 4 Other
 - 1 refer to Sunbridge, Burlingame (Out of county patient)
 - 1 refer to San Mateo SNF (San Mateo resident)
 - 1 refer to Oakland (Oakland resident)
 - 1 refer to UCSF for radiation cancer treatment

TOTAL MEDICAL-SURGICAL PATIENTS IDENTIFIED: 21

Psychiatry

- ♦ 3 Needs placement in CHN Long Term Care
 - 3 are awaiting LHH admissions
- ♦ 2 Needs placement in other Long Term Care
 - 1 awaiting approval from Fremont
 - 1 waiting for bed at Canyon Manor
- ♦ 2 awaiting decision from CMHS regarding long term care placement

TOTAL IDENTIFIED PSYCHIATRY PATIENTS: 7

Mental Health Rehabilitation Facility

Current Census: 142 beds with 5 beds holds

Budgeted Census: 140 beds

Capacity: 147 beds

- ♦ 39 identified as needing community placement
 - ♦ 8 referred to residential care and placement has not been identified
 - ♦ 2 accepted to residential care and awaiting bed
 - ♦ 4 residential care referrals put on hold pending restabilization of symptoms
 - ♦ 13 Asian Residents will be placed at Broderick House when it opens
 - ♦ 5 medical residents with medical needs for Broderick House
 - ♦ 1 accepted to residential treatment, pending case management treatment
 - ♦ 4 awaiting residential treatment
 - ♦ 2 will go to hotels pending case management linkages

TOTAL IDENTIFIED AT MHRF FOR PLACEMENT: 39

OVERALL TOTAL OF DECERTIFIED PATIENTS/RESIDENTS: 67

- ♦ CHN Patients/Residents Waiting for LHH: 12
- ♦ CHN Patients/Residents Waiting for Community Placement 43
- ♦ Patients waiting for 4A 6
- ♦ CHN Patients/Residents Awaiting CMHS Placement 2
- ♦ Other 4

San Francisco General Hospital

Diversion Report

January 2001

Executive Summary

The Emergency Department [ED] recorded 59 episodes of diversion for 324 hours representing a rate of **44% for January 2001**. This is a 16% increase in diversion since December.

The 59 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	Change from previous month
Total diversion	49	280	38%	14% increase
Trauma over-ride	10	44	6%	2% increase

The ED was impacted by capacity, high patient acuity and understaffing during the episodes of total diversion. During this time, **260** patients were awaiting admission to in-patient beds [ICU-22, 4B/StepDown-82, **MedSurg-156**]. In December 2000, the ED cared for 162 patients waiting for admission. The number of patients waiting for 4B/StepDown at the time of diversion increased in January to 82 compared to 73 December 2000. The number of med/surg admissions jumped to 156 patients in January 2001 from 70 in December 2000.

ED understaffing of Physicians, residents, nurses and techs was identified during all diversion episodes. At the point diversion was initiated, the ED was actively providing treatment for a range of 25-43 patients in the clinical area.

In comparison, data from January 2000 show a 16.2% total diversion rate for 126 hours in 27 episodes; the ED was holding 77 patients awaiting admission to the hospital.

Trauma override was recorded for 10 episodes for a total of 44 hours or a 6% rate for January 2001. This is a 2 % increase in trauma override from December. Trauma over-ride was invoked a total of 7 times or 4% in January 2000.

*Prepared by: Pat Nagle R.N.
Base Hospital Coordinator*

*Christine Wachsmuth, RN, MS
Associate Hospital Administrator*

San Francisco General Hospital
Emergency Department
JANUARY 2001
Trauma Override Summary

The Emergency Department recorded 10 episodes of Trauma Override for 44 hours, a percentage of 6 % for the month.

Date	Length	Summary of Event
1/02/01	2325-0300	911-1 912-3 2-4B/ 1-ICU {Waiting for in patient bed}
1/04/01	2130-0300	911-1 912-1 2-4B/ 1-ICU/ 5-med-surg
1/05/01	1955-2145	911-1 912-2 1-4B/ 1-ICU/ 3-med-surg
1/06/01	0530-0607	911-1 912-2 1-4B/ 1-ICU/ 4-med-surg
1/08/01	1610-0435	911-1 3-4B/2-ICU/ 6-med-surg
1/11/01	1450-1700	911-1 912-1 2-4B/ 1-med-surg
1/14/01	1815-2300	912-2 1-4B/ 1-ICU/ 4-med-surg
1/16/01	1748-1905	911-1 912-2 4-4B/ 1-med-surg
1/22/01	1530-1845	911-3 912-2 6-4B/ 1-ICU/ 2-med-surg
1/28/01	0310-1115	911-2 912-1 8-med-surg

Trauma Patient Definitions:

- 911 is a critical adult trauma patient requiring the immediate life saving attention of the trauma team
- 912 is a potentially critical adult trauma patient requiring the prompt attention of the trauma team
- 910 is a critical pediatric patient requiring the immediate life saving attention of the trauma team including pediatricians
- 999 is a multiple casualty incident code involving 3 or more critical trauma patients

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES
JANUARY 2001
(In Thousands of Dollars)

MONTH-TO-DATE						ANNUAL					
Line No.	Fav/(Unfav)						Fav/(Unfav)				
	Actual	Budget	Variance	% Var	Prior Year		Projection	Budget	Variance	% Var	Prior Year
GROSS PATIENT REVENUE:											
1	9,276	14,216	(4,939)	-35%	12,394	Inpatient Medi-Cal Revenue	158,252	162,186	(3,934)	-2%	150,619
2	4,500	4,442	57	1%	3,562	Outpatient Medi-Cal Revenue	49,312	50,683	(1,371)	-3%	47,210
3	6,068	4,903	1,165	24%	5,285	Inpatient Medicare Revenue	57,962	55,937	2,025	4%	54,766
4	2,181	1,958	223	11%	2,026	Outpatient Medicare Revenue	22,092	22,334	(242)	-1%	21,725
5	13,596	7,130	6,465	91%	6,073	Inpatient Other Revenue	96,153	81,339	14,814	18%	83,296
6	5,105	5,089	16	0%	4,738	Outpatient Other Revenue	59,395	58,056	1,339	2%	59,349
7	<u>40,726</u>	<u>37,738</u>	<u>2,988</u>	<u>8%</u>	<u>34,077</u>	TOTAL PATIENT SERVICE REVENUE	<u>443,166</u>	<u>430,535</u>	<u>12,631</u>	<u>3%</u>	<u>416,965</u>
REVENUE DEDUCTIONS:											
8	11,583	6,136	(5,447)	-89%	7,934	Charity Care	70,706	70,000	(707)	-1%	58,268
9	13,248	13,146	(102)	-1%	8,610	Provision for Medi-Cal Adjustments	156,296	149,972	(6,323)	-4%	149,060
10	7,389	2,454	(4,934)	-201%	3,470	Provision for Medicare Adjustments	28,740	28,000	(740)	-3%	27,475
11	(2,798)	4,249	7,047	166%	(5,604)	Provision for Other Adjustments	49,844	48,463	(1,381)	-3%	53,287
12	1,917	1,917	(0)	0%	9,556	Provision for Bad Debt	23,000	23,000	0	0%	23,598
13	<u>31,337</u>	<u>27,901</u>	<u>(3,436)</u>	<u>-12%</u>	<u>23,967</u>	TOTAL REVENUE DEDUCTIONS	<u>328,586</u>	<u>319,435</u>	<u>(9,151)</u>	<u>-3%</u>	<u>311,688</u>
14	<u>9,388</u>	<u>9,836</u>	<u>(448)</u>	<u>-5%</u>	<u>10,110</u>	NET PATIENT SERVICE REVENUE	<u>114,581</u>	<u>111,101</u>	<u>3,480</u>	<u>3%</u>	<u>105,277</u>
OTHER OPERATING REVENUE:											
15	276	663	(387)	-58%	(824)	Capitation	7,959	7,959	0	0%	6,248
16	388	388	0	0%	308	Short Doyle	4,654	4,654	0	0%	5,359
17	704	704	0	0%	704	MHRF Funding	8,453	8,453	0	0%	8,453
18	10,626	10,626	0	0%	11,469	S8855	127,518	127,518	0	0%	91,373
19	1,808	1,808	0	0%	3,667	S81255	21,700	21,700	0	0%	21,700
20	108	108	0	0%	750	GME	1,300	1,300	0	0%	1,300
21	830	0	830	#DIV/0!	0	Rev from other city departments	9,960	9,960	0	0%	9,654
22	0	0	0	#DIV/0!	1,494	Prior Year Settlement	0	0	0	#DIV/0!	(667)
23	292	292	0	0%	393	MAA & Other Net Patient Revenue	3,500	4,065	(565)	-14%	4,363
24	<u>15,033</u>	<u>14,590</u>	<u>443</u>	<u>3%</u>	<u>17,961</u>	OTHER OPERATING REVENUE	<u>185,044</u>	<u>185,608</u>	<u>(565)</u>	<u>0%</u>	<u>147,783</u>
25	<u>24,422</u>	<u>24,427</u>	<u>(5)</u>	<u>0%</u>	<u>28,071</u>	TOTAL OPERATING REVENUE	<u>299,624</u>	<u>296,709</u>	<u>2,915</u>	<u>1%</u>	<u>253,060</u>
OPERATING EXPENSES:											
26	13,704	13,226	(478)	-4%	12,201	Personnel Services	153,840	151,158	(2,682)	-2%	148,920
27	3,131	3,018	(113)	-4%	2,920	Mandatory Fringe Benefits	36,201	34,490	(1,710)	-5%	35,819
28	8,255	8,410	155	2%	7,441	Contractual Services	98,966	101,566	2,600	3%	85,717
29	2,148	2,148	0	0%	2,020	Materials and Supplies (Excl. Pharmaceuticals)	25,775	25,775	0	0%	22,433
30	1,200	1,000	(200)	-20%	1,008	Pharmaceuticals	14,390	12,000	(2,390)	-20%	14,956
31	383	382	(1)	0%	252	Facilities Maint. & Capital Outlay	4,593	4,593	0	0%	1,385
32	1,207	1,245	38	3%	961	Services of Other Departments	14,480	14,938	458	3%	13,251
33	(106)	(936)	(830)	89%	(1,036)	Expenditure Recovery	(1,272)	(1,272)	0	0%	(927)
34	8,185	8,185	0	0%	8,185	Operating Transfer Out	98,225	98,225	0	0%	63,914
35	187	187	0	0%	133	Intrafund Transfer	2,248	2,248	0	0%	1,590
36	0	0	0	#DIV/0!	2,500	S81255 & GME IGT	0	0	0	#DIV/0!	0
37	428	428	(0)	0%	278	Projects	5,131	5,131	0	0%	1,890
38	<u>38,721</u>	<u>37,294</u>	<u>(1,428)</u>	<u>-4%</u>	<u>36,862</u>	TOTAL OPERATING EXPENSES	<u>452,577</u>	<u>448,853</u>	<u>(3,724)</u>	<u>-1%</u>	<u>388,947</u>
39	<u>(14,300)</u>	<u>(12,867)</u>	<u>(1,433)</u>	<u>-11%</u>	<u>(8,791)</u>	OPERATING INCOME/(LOSS)	<u>(152,952)</u>	<u>(152,144)</u>	<u>(808)</u>	<u>-1%</u>	<u>(135,887)</u>
NON-OPERATING REVENUE:											
40	5,925	5,925	0	0%	3,086	General Fund	71,104	71,104	0	0%	65,350
41	5,093	5,093	0	0%	4,818	Realignment	61,113	61,113	0	0%	58,733
42	317	312	5	2%	496	Prop 99	3,807	3,722	84	2%	6,101
43	212	205	7	3%	873	Transfer In	2,547	2,547	0	0%	2,265
44	838	836	2	0%	825	Carryforward	10,053	10,053	(0)	0%	0
45	73	87	(14)	-16%	81	Cafeteria	877	1,039	(162)	-16%	877
46	439	214	226	106%	565	Miscellaneous	2,952	2,565	387	15%	2,905
47	<u>12,898</u>	<u>12,672</u>	<u>226</u>	<u>2%</u>	<u>10,744</u>	NON-OPERATING REVENUE	<u>152,453</u>	<u>152,144</u>	<u>309</u>	<u>0%</u>	<u>136,231</u>
48	<u>(1,402)</u>	<u>(196)</u>	<u>(1,207)</u>		<u>1,953</u>	NET INCOME/(LOSS)	<u>(499)</u>	<u>(0)</u>	<u>(499)</u>		<u>344</u>

**SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION
JANUARY 2001**

Line No.	CURRENT MONTH					KEY VOLUME INDICATORS	YEAR-TO-DATE				
	Actual	Budget	Variance	% Var	Prior Year		Actual	Budget	Variance	% Var	Prior Year
						Acute Activity					
1	1,464	1,616	(152)	-9%	1,616	Discharges	10,510	11,493	(983)	-9%	11,493
2	2,060	2,323	(263)	-11%	2,300	Adjusted Discharges	14,786	16,523	(1,737)	-11%	16,406
						Average Daily Census					
3	196	189	7	4%	207	Acute Med/Surg ADC	191	182	9	5%	199
4	91	92	(1)	-1%	93	Psych ADC	92	94	(2)	-2%	95
5	25	24	1	6%	25	Skilled Nursing ADC	22	22	(0)	-2%	23
6	312	305	7	2%	325	Subtotal ADC Excl. MHRF	305	298	7	2%	317
7	138	140	(2)	-1%	122	MHRF ADC	135	140	(5)	-3%	125
8	451	445	6	1%	447	Subtotal Adult ADC	441	438	3	1%	443
9	6	7	(1)	-16%	15	Nursery ADC	7	7	(0)	-3%	13
10	6.7	5.9	(0.8)	-14%	6.3	Average Length of Stay (excl. MHRF)	6.3	5.6	(0.7)	-13%	6.0
11	1.227	1.295	(0.1)	-5%	1.288	Medicare Case Mix Index	1.227	1.295	(0.1)	-5%	1.288
						Payor Mix (Gross Revenue)					
12	34%	49%	-16%		47%	Medi-Cal	45%	49%	-4%		49%
13	20%	18%	2%		21%	Medicare	18%	18%	0%		18%
14	46%	32%	14%		32%	Other	37%	32%	4%		33%
15	100%	100%	0%		100%	Total	100%	100%	0%		100%
						Patient Days					
16	5,275	5,715	(440)	-8%	6,018	Medi-Cal Patient Days (excl. MHRF)	36,828	38,940	(2,112)	-5%	41,880
17	2,243	1,992	251	13%	2,323	Medicare Patient Days (excl. MHRF)	14,334	13,604	730	5%	13,962
18	2,158	1,742	416	24%	1,744	Other Patient Days (excl. MHRF)	14,675	11,527	3,148	27%	12,412
19	9,676	9,449	227	2%	10,085	Total Patient Days (excl. MHRF)	65,837	64,071	1,766	3%	68,254
20	5,905	6,562	(657)	-10%	6,431	Medi-Cal Patient Days (incl. MHRF)	41,417	44,814	(3,397)	-8%	47,380
21	2,317	2,017	300	15%	2,285	Medicare Patient Days (incl. MHRF)	14,630	13,774	856	6%	14,040
22	5,744	5,210	534	10%	5,150	Other Patient Days (incl. MHRF)	38,993	35,582	3,411	10%	33,745
23	13,966	13,789	177	1%	13,866	Total Patient Days (incl. MHRF)	95,040	94,171	869	1%	95,165
25	19,654	19,824	(170)	-1%	19,736	Adj. Patient Days	133,702	135,389	(1,687)	-1%	135,851
26	29%	30%	-2%	-5%	30%	Outpatient Charges as a % of Total Charges	29%	30%	-2%	-5%	31%
27	84%	83%	1%	1%	83%	% Occupancy (available beds)	82%	82%	0%	1%	82%
						KEY OPERATIONAL INDICATORS					
						Labor					
28	2,207	2,296	90	4%	2,343	FTEs - Productive	2,246	2,296	51	2%	2,340
29	424	313	(111)	-36%	351	FTEs - Non-Productive	362	313	(49)	-16%	356
30	2,631	2,610	(22)	-1%	2,694	FTEs - Total	2,608	2,610	1	0%	2,697
31	334	334	0	0%	351	UC Non-Academic FTEs	334	334	0	0%	351
32	2,965	2,944	(22)	-1%	3,045	Total FTEs	2,942	2,944	1	0%	3,048
33	4.7	4.6	(0.1)	-2%	4.8	FTEs Per AOB (incl. UC)	4.7	4.7	(0.0)	0%	4.8
34	\$60,094	####	(902)	-2%	\$56,514	Labor Cost per FTE	\$58,750	####	(916)	-2%	\$56,046
35	23%	23%	0%	0%	24%	Fringe Benefits as % of Salary	24%	23%	-1%	-3%	23%
36	330	227	103	45%	259	Vacancy positions	330	227	103	45%	259
						Revenues					
37	\$1,243	\$1,232	\$10	1%	\$1,422	Oper. Revenue per adj. Pat. Day	\$1,304	\$1,248	\$55	4%	\$1,346
38	\$604	\$599	\$5	1%	\$617	Oper. Rev. (excl. S8855/1255/GME)/APD	\$647	\$600	\$47	8%	\$527
39	\$11,854	\$10,514	\$1,340	13%	\$12,205	Oper. Revenue per adj. Discharge	\$11,787	\$10,231	\$1,556	15%	\$11,142
40	\$5,766	\$5,115	\$651	13%	\$5,298	Oper. Rev. (excl. S8855/1255/GME)/adj. Discharge	\$5,849	\$4,915	\$934	19%	\$4,364
						Expenses					
41	\$1,970	\$1,881	(\$89)	-5%	\$1,868	Operating Exp. Per adj. Pat. Day	\$1,973	\$1,879	(\$93)	-5%	\$1,933
42	\$1,554	\$1,468	(\$85)	-6%	\$1,326	Operating Exp. (excl. IGT)/adj. Pat. Day	\$1,544	\$1,456	(\$88)	-6%	\$1,382
43	\$18,795	####	(\$2,743)	-17%	\$16,027	Operating Exp. Per adj. Discharge	\$17,837	####	(\$2,435)	-16%	\$16,006
44	\$14,822	####	(\$2,293)	-18%	\$11,381	Operating Exp. (excl. IGT)/adj. Discharge	\$13,962	\$11,933	(\$2,029)	-17%	\$11,445
45	36%	32%	-4%	-11%	30%	Supply Exp. as % of net Pt. Rev.	35%	33%	-2%	-6%	39%
46	113	120	7	6%	134	Days Revenue in Accounts Receivable	113	120	7	6%	134

* data not available, assumed prior month's actual.

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

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Harrison Parker, Sr., D.D.S.
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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, March 13, 2001
3:45 p.m. – 5:30 p.m.
San Francisco General Hospital
1001 Potrero, Rm. 2A6 Conference Room
San Francisco, CA 94110

1st Printed 3/8/01
DOCUMENTS DEPT

Commissioner Lee Ann Monfredini, Chairperson
Commissioner John I. Umekubo, M.D.

MAR 12 2001

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: CONSIDERATION OF APPROVING THE MINUTES FOR FEBRUARY 13, 2001
*Minutes of February 13, 2001
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
- 4) FOR DISCUSSION: UPDATE ON THE SFGH REBUILD PLANNING COMMITTEE

- 5) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
**Report*
- 6) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Ken Jensen, Chief Financial Officer, CHN)
**Report*
- 7) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**
- 8) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION
- 9) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF FEBRUARY 13, 2001

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

10) RECONVENE IN OPEN SESSION

VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION, (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(a) (ACTION ITEM))

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web-site at: www.ci.sf.ca.us/bdsupvrs/sunshine

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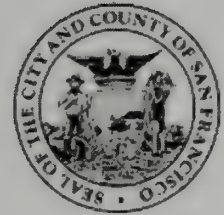
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Commissioner

HEALTH COMMISSION

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MINUTES

JOINT CONFERENCE COMMITTEE MEETING FOR SAN FRANCISCO GENERAL HOSPITAL

Tuesday, March 13, 2001

3:45 p.m.

**1001 Potrero Avenue, Room #2A6
San Francisco, CA 941102**

1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Chairperson Commissioner Lee Ann Monfredini at 3:45 p.m.

Present: Commissioner Lee Ann Monfredini

Absent: Commissioner John I. Umekubo, M.D.

CHN Staff: Gene O'Connell, Tony Wagner, Phil Hopewell, M.D., Hiro Tokubo, Fanny Lee, Connie Young, Alison Moed, Carlos Villalva, Alan Gelb, M.D., M.D., Melinda Garcia, Sue Currin, Monique Zmuda, John Luce, M.D., Art Greenberg

Commissioner Monfredini announced that Art Greenberg will be the Interim Executive Secretary while the Commission goes through the process of hiring a new Executive Secretary.

Flowers, gifts, and cake were presented to outgoing Executive Secretary, Sandy Mori, from SFGH and the Medical Staff Office.

2) APPROVAL OF MINUTES OF THE JCC-SFGH MEETING OF FEBRUARY 13, 2001.

Action Taken: The Committee adopted the minutes of February 13, 2001.

3) **HOSPITAL HEALTHCARE UPDATE**
(Gene O'Connell, Executive Administrator,
San Francisco General Hospital Medical Center)

Plans for a New Patient and Visitor Assistance Center

Through the generous financial assistance and support from the SFGH Foundation and SFGH Volunteers, SFGH is currently planning to develop a new patient and visitor assistance center. The Center would be located in the existing main hospital lobby to serve as a gateway for hospital and medical center patients, visitors, and the community. Through the Center, SFGH aims to accomplish the following:

- ?? Provide patients and visitors with information regarding SFGH services and resources
- ?? Assist patients and visitors with way-finding within the campus and hospital
- ?? Address and direct patients' and visitors' concerns, grievances and complaints
- ?? Assist patients with questions and issues related to medical bills and insurance coverage

A SFGH Design Team co-chaired by Gloria Garcia-Orme, Director of Patient/Visitor Relations; and Renee Cibulka, Director of Volunteer Services, are reviewing various layouts for the Center. Through the generosity and the support of the SFGH Foundation, the Foundation has hired Tsang Architecture to assist the Design Team in both design and project management. The SFGH Design Team will build upon work that was done by previous Continuous Quality Improvement (CQI) teams at SFGH, which identified the need for a "May I help you?" center.

Functional areas under discussion to be included in the Center include:

- ?? Reception and Information Space
- ?? Complaint and Grievance Room
- ?? Financial and Eligibility Services
- ?? Admitting Waiting Area
- ?? Discharge Lounge
- ?? General Main Lobby Waiting
- ?? Support Spaces
- ?? Adjacency to security kiosk, gift shop, and cashier

Next steps for the Design Team include presentation of the various schematic designs to the SFGH Facilities Advisory Board (FAB), and, ultimately to the SFGH Foundation, for approval and funding. As plans become finalized, they will be presented the JCC-SFGH.

Expansions of Outpatient Substance Abuse Services (OTOP)

During this past year the Opiate Treatment Outpatient Program (OTOP) began an Expansion Plan in order to meet the increased need/demand for treatment of an increasingly high-risk patient population. The Expansion Plan has afforded us the opportunity to create new treatment modalities, partnerships with community based programs, access to Federal grant monies, as well as increased collaboration with hospital based units.

The current components of this Expansion Plan are as follows:

1. Increased licensed capacity to 750 treatment slots.
2. 40 Identified treatment slots for ISIS (SFGH Clinic) patients (15 enrolled)
3. 30 Identified treatment slots for ED Linkage (NIH/NIDA) patients (15 enrolled)
4. 40 Identified treatment slots for Action Point HIV Bayview Hunters Point (BVHP) (C-SAT) patients.
5. Development of a program for 20 Medically Assisted Detox beds at Ozanam Center (CSAS funds).
6. Development of a Mobile Van Dispensing Unit (C-SAT), which will begin with 50 treatment slots.
7. Increased 45 CSAS slots for CHN patients (completed).
8. Increased Detox capacity for ISIS patients (completed).

The Expansion has created some challenges both from a staffing and space perspective, however, it is an exciting time for program development, implementation and growth. OTOP has increased service to this high-risk patient population in both Detox and Maintenance segments of the program in lieu of the challenges.

This increase is reflected in the census:

<u>February 1, 2000</u>	<u>February 1, 2001</u>	<u>% increase</u>
328	431	24%

As the Expansion enters the next phase, one of the main goals is to increase integrated services for this patient population, in addition to facilitating primary care referrals. This will improve the patient's health care, decrease the demand/cost of acute care and impact the overall public health issues.

Trauma Plan

The EMS Agency has been charged with revising the CCSF Trauma Plan to bring the Plan into compliance with the new Title 22 regulations on trauma care and systems. The regulations became effective in August 1999. However, the EMS Agency is not required to submit the updated CCSF Trauma Plan to the State EMS Authority until August 12, 2001. The State has mandated a trauma Plan format incorporating 13 required elements and written evidence of local approval of the revised plan. San Francisco's current trauma system plan was approved by the Health Commission and by the State EMS Authority in 1990.

The State Authority has 60 days to approve, reject or require revisions for the CCSF Trauma Plan. The EMS Agency will be submitting for public comment the Plan to SFGH, other hospitals in the City and emergency and medical professionals during March and April. SFGH will be convening a group of physicians, clinical staff and managers to review the Plan from the Trauma Center's perspective and provide critique and feedback to the EMS Agency staff.

Earthquake Exercise – April 18, 23001

April is Earthquake Preparedness Month in California. A variety of activities are scheduled at San Francisco General Hospital. The highlight of the month will be a functional emergency exercise held at SFGH on the morning of April 18, 2001. The exercise will include volunteer victims staged in a collapse site. Preparations are underway for a joint exercise operation between the hospital and the

San Francisco Fire Department. The scenario detailed below will require hospital wide mobilization of resources as well as support of outside responders.

Planning

An exercise of this size and scope will require both internal and external coordination efforts. Outside resources will include, but are not limited to the San Francisco Fire Department (SFFD), the SFFD EMS and Special Operations Sections, the Mayor's Office of Emergency Services, and the San Francisco Emergency Medical Services Section.

Individual departments are requested to develop their own set of goals and objectives. It will be the responsibility of the exercise controller to incorporate these individual plans as best possible to meet the exercise objectives.

The Exercise

A functional emergency exercise will be held at SFGH on the morning of April 18, 2001. This date is the anniversary of the 1906 Earthquake that killed 3000 people in the Bay Area. The exercise is designed to evaluate the current awareness and abilities of individual departments to respond to emergency response activation.

The focal point of the exercise will be the site of a simulated collapse with trapped victims. This staged site will be the first and second floors of the Medical Library, the hallways of Building 30 and the Campus lawn. Additional sites may be added.

This exercise is a component of the disaster response program at SFGH, as well as a kick-off for Neighborhood Emergency Response Team (NERT) training to be held at SFGH from April 24-May 29.

The overall goal of this exercise is the continued development and ongoing training for the hospital emergency response plan. Exercise controllers will be on hand at key sites to facilitate problem-solving and ensure the flow of the event.

Announcements

Take Your Daughters to Work – San Francisco General Hospital Medical Center

San Francisco General Hospital Medical Center, once again, will be sponsoring a "Take Your Daughters to Work" Day on April 26, 2001. LaFrancine Tate, as in the past, will be chairing this event with co-chairs Katherine Mah, Nurse Educator; and Joan Fierberg, Director of Library Information Services. This year, nine departments at SFGHMC will be participating to provide hands-on experiences for all youth participants.

This event is open to children ages 9 to 14 years old of all SFGHMC staff. Sign-up sheets for the event will be available later this week.

Commissioner Monfredini pointed out space for confidentiality and marketing is needed in the Patient and Visitor Assistance Center. She also recommended the overseer of the Center should not report to the CEO of the hospital.

On the Trauma Plan, which will come to the JCC-SFGH in June, Commissioner Monfredini and Mr. Wagner raised the issue of recommendations going to the full Commission in June instead of July. Ms. O'Connell reported the staff had a community meeting in the SFGH cafeteria.

4) UPDATE ON THE SAN FRANCISCO GENERAL HOSPITAL REBUILD PLANNING COMMITTEE

Gene O'Connell, Executive Administrator of SFGH, reviewed a report for the SFGH Rebuild, which includes various options for the programmatic, technical, and finance aspects. The full report is available in the Commission Office (554-2666)

The report covers the estimated project cost, program options, site options, site size, parking, a service building, equipment legislative update, and timeline options.

Ms. O'Connell stated there's a need to answer other questions and to do some master-planning for SFGH.

Commissioner Monfredini stated her opinion that a ballot measure on November 2001 is out of the question; she also does not support a March election. Instead, she would like to look at November 2002, so there would be more time to plan and to have discussions with UCSF.

Dr. Phil Hopewell raised the issue of how research and academics would be included in a SFGH rebuild.

This report will be presented to the full Commission on March 20, 2001.

5) PATIENT CARE REPORT
(Sue Currin, R.N., Chief Nursing Office)

Ms. Currin submitted her report (Attachment A), and a Diversion Report (Attachment B)

6) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Monique Zmuda, Chief Financial Officer, DPH)

Ms. Zmuda submitted the 8-month Revenue and Expenses ending February 28, 2001, and the Summary Statistical Information (Attachment C).

7) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL

None.

8) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION

None.

The Committee went into Closed Session at 5:05 p.m.

Individuals present in the Closed Session were the same as in the Open Session, except for Fanny Lee

9) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 14641; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

Action Taken: The Committee approved the Closed Session minutes of February 13, 2001

**CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE,
QUALITY ASSURANCE AND CREDENTIALING MATTERS**

The Committee came out of Closed Session at 5:23 p.m.

10) **RECONVENE IN OPEN SESSION**

Action Taken: The Committee voted not to disclose any discussions held in Closed Session, (San Francisco Administrative Code Section 67.12(a).

The meeting was adjourned at 5:25 p.m.

Sandy Ouye Mori
Executive Secretary to
the Health Commission

Attachments (3)

Roma P. Guy, M.S.W.
President

Edward A. Chow, M.D.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

John L. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

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Arthur R. Greenberg
Interim Health Commission Secretary

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MINUTES

JOINT CONFERENCE COMMITTEE MEETING FOR

SAN FRANCISCO GENERAL HOSPITAL DOCUMENTS DEPT.

Tuesday, April 10, 2001
3:45 p.m.

1001 Potrero Avenue, Room #2A6
San Francisco, CA 941102

MAY - 7 2001

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PUBLIC LIBRARY

1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Commissioner John I. Umekubo, M.D., at 3:45 p.m.

Present: Commissioner John I. Umekubo, M.D.

Absent: Commissioner Lee Ann Monfredini

CHN Staff: Mitchell Katz, M.D., Sue Currin, Melinda Garcia, Alan Gelb, M.D.,
Fanny Lee, John Luce, M.D., Alison Moed, Gene O'Connell, Hiro Tokubo,
Kathryn Thurow, Anthony Wagner, Chris Wachsmuth, Connie Young

2) APPROVAL OF MINUTES OF THE JCC-SFGH MEETING OF MARCH 13, 2001

Action Taken: The Committee adopted the minutes of March 13, 2001.

3) HOSPITAL HEALTHCARE UPDATE

(Gene O'Connell, Executive Administrator,
San Francisco General Hospital Medical Center)

SURVEY OF CITY FACILITIES FOR ENERGY CURTAILMENT PROGRAM

As requested by the Public Utilities Commission (PUC), San Francisco General Hospital, in representing the Department of Public Health, responded to the PUC's survey on energy efficiency

measures. Out of all of the City departments, 14 departments did not respond to the PUC survey. John Kanaley, Director of Facilities, serves as the point person for the Department of Public Health in relaying to the PUC our efforts to curtail our use of energy.

ROTATING POWER OUTAGES

San Francisco General Hospital Medical Center is exempt from rotating outages as mandated by the California Public Utilities Commission (CPUC). However, the Mental Health Rehabilitation Facility (MHRF) is not exempt. The MHRF was subjected to a rotating blackout on Monday, March 19, 2001, from 6:35-7:40 p.m. All backup generator within 10 seconds per Title 22 requirements. There were no adverse effects on patient care due to this outage.

A follow-up critique was conducted by Plant Services. Three minor improvements will be made before April 30, 2001 to address identified issues. They are as follows:

1. Kitchen lighting was insufficient
2. SureMed dispensers not on emergency power
3. South fire door is not on emergency power

Exemption Status for Hospitals

During the 1970's, the CPUC adopted a priority system for the curtailment of electricity during periods of time where the demand exceeded the supply. At that time hospitals with 100 beds or more were determined to be exempt from rotating outages. In a further review in 1982, it was determined that customers with sufficient standby generative equipment for their essential load would not be protected from rotating outages. Over the past few months, PG&E and Southern California Edison began to include hospitals with sufficient standby generating equipment in their rotating outages. On March 23, 2001, CPUC clarified their ruling and passed a motion declaring all hospitals with 100 beds or more shall be exempt from rotating outages. This ruling does not include skilled nursing facilities.

SFGHMC Plant Services Department is working with the CCSF Office of Emergency Services (OES) and PG&E to clarify the CPUC's ruling on skilled nursing facilities. We believe we may be capable of applying an exemption status to the MHRF as it is licensed under the hospital license and 215 beds. Paperwork requesting clarification from PUC should be sent out by April 9, 2001.

All other buildings on the SFGHMC campus, except the MHRF, receive their power through the main hospital distribution system, therefore making their supply of electrical power exempt from rotating outage.

Ms. O'Connell will continue to provide updates to the JCC-SFGH she receives more information.

REMINDER: EARTHQUAKE EXERCISE – APRIL 18, 2001

As reported in the last Hospital Healthcare Update Report, April is Earthquake Preparedness Month in California. On the morning of April 18, 2001, SFGH will be coordinating a functional emergency exercise with participation from the San Francisco Fire Department (SFFD), SFFD EMS and Special Operations Sections, the Mayor's Office of Emergency Services, and the San Francisco Emergency Medical Services Section.

In order to make the exercise as representative of an actual earthquake, coordinators are hoping to receive the participation of 100 volunteers to act as victims. They are still looking for volunteers and, if individuals are interested, they should contact Ann Stangby, Disaster Coordinator, at 206-3397.

SFGH/UCSF AFFILIATION AGREEMENT

San Francisco General Hospital Medical Center and the UCSF Dean's Office have hired ECG Management Consultants to aid in the development of a revised payment methodology for the UC Contract. ECG is familiar with the organizational structure of both SFGHMC and UCSF, as well as the U.C. Contract, having worked on the U.C. Contract five years ago.

To gain an understanding of both parties' concerns and issues connected to the U.C. Contract, a Steering Committee consisting of Gene O'Connell, Philip Hopewell, Monique Zmuda, and Cathryn Thurow has been created.

By direction of the Steering Committee, ECG will be identifying which payment model will maximize potential revenue while addressing both parties' concern of defining what unit is being purchased through the contract (FTEs vs. service), basis for purchasing through the contract, and determining the process of discussing changes in the contract. In their first steps to determine which payment model best suits the contract, ECG will begin looking at our outpatient services.

INQUIRIES CONNECTED TO THE TRAUMA FOUNDATION AND THEIR RELATIONSHIP WITH THE MILLION MOM MARCH FOUNDATION

In February 2001, SFGHMC began receiving multiple inquiries regarding our relationship to the Million Mom March Foundation. Individuals who are affiliated with pro-gun organizations initiated these inquiries. They have requested information, through the Public Records Act, focused on the amount of rent-free space that is provided to the Trauma Foundation on the SFGHMC Campus.

SFGHMC has had a long, mutually beneficial relationship with the Trauma Foundation dating back to 1973 when the Foundation was first established as the Burn Council. The Burn Council evolved into the Trauma Foundation in 1980.

Since SFGHMC is the City's only Trauma Center, it has a vested interest in trauma and violence prevention. Trauma and violence prevention is also the primary mission of the Trauma Foundation. Accordingly, in order to facilitate a close relationship and joint efforts regarding these issues, SFGHMC has provided rent-free space in Building 30 to the Trauma Foundation for well over a decade.

In 1998, the Trauma Foundation received a grant for a program called the "Bell Campaign". This grant focused specifically on injury prevention related to guns.

The Bell Campaign was started as a stand-alone non-profit 501(c)3 organization. In 2000, the Million Mom March campaign was launched. Due to the infrastructure that the Bell Campaign already had in place and the mission that it shared with the Million Mom March Campaign, the "Bell Campaign" was transformed into the Million Mom March Foundation. Additionally, its tax status was changed to 501(c)4. Under this new tax status, the Million Mom March Foundation was still a non-profit; however, it could now engage in lobbying activities.

As the Million Mom March Foundation grew and began lobbying activities, it also leased additional space on South Van Ness; however, its relationship with the Trauma Foundation remained very close.

The Million Mom March Foundation tried to ensure that its lobbying activities operated from its Van Ness office; however, for conveniences sake, it frequently used the Trauma Foundation's SFGHMC address.

All of this has set a complex stage for allegations that SFGHMC has improperly allowed City resources to be used for gun lobbying activities. Gun activists have submitted several request for information under the Public Records Act, made repeated phone calls to administrative staff, made visits to the SFGHMC campus, posted notes regarding SFGHMC on various pro-gun web sites, and published an article regarding this matter in Gun Weekly.

SFGHMC feels strongly that it should continue its efforts to approach violence as a public health issue. To this end, the presence of the Trauma Foundation on the SFGHMC campus is mutually beneficial. The gun activists have yet to make a single argument or allegation to make us even question this position.

We have also had numerous conversations with the City Attorney's Office regarding this arrangement. They have found no legal basis as to why SFGHMC can not permit the Trauma Foundation to occupy space on the SFGHMC campus at no charge.

SFGHMC will continue to monitor the situation and keep you informed.

CITY AND COUNTY OF SAN FRANCISCO TRAUMA PLAN

Trauma Plan Overview

The State of California has updated trauma regulations in Title 22 for both Trauma Centers and Systems throughout the State. SF County, through its EMS Agency must submit a Health Commission approved Title 22 compliant Trauma System Plan to the State EMS Authority by August 12, 2001. As the only designated SF County Trauma Center, SFGH and its trauma operations are a key component of this Plan. A draft plan has been written by the SF EMS Agency and is now in the "public comment" period until May 7.

This version of the SF Trauma Plan is the first revision of the plan originally approved by the State in 1990. In 1991 the American College of Surgeons designated SFGH as the County's Level 1 Trauma Center after a trauma center verification site survey. Consequently, the 2001 Trauma Plan was completely re-written incorporating the following state mandated components:

- Trauma system needs assessment including fiscal impact to system
- Plan design inclusive to all receiving hospitals, EMS field providers, the Trauma Center, and the local EMS Agency
- Trauma Center and other hospitals must participate in EMS directed data reporting and system performance improvement processes
- Coordination with neighboring trauma systems, and
- Trauma system evaluation program.

Impact on SFGH Trauma Center

Trauma Center physicians and SFGH Administrators convened recently to discuss the key components of the new plan and its impact on SFGH operations. The consensus was that SFGH will be able to meet the new Title 22 trauma requirements for a Level 1 Center as these regulations are nearly identical in scope and intent to the new American College of Surgeons [ACS] trauma standards. SFGH is now intensively preparing for an ACS site survey to be scheduled for late winter/early spring 2002. The ACS will jointly conduct this designation – trauma center verification

survey with the SF EMS Agency. Since SFGH provides Level 1 trauma services to San Mateo County, that EMS Agency will also be notified of the trauma survey results.

Areas of the plan, which will require further SFGH attention, include:

- Participation in a trauma data management system to-be-developed by the EMS Agency (data elements must include: ED, ICU and OR patient care information, discharge diagnosis and date, hospital charge information, treatment dates, times)
- Transfer agreements with other trauma centers
- Pediatric trauma transfer issues (where and how)
- Trauma diversion (circumstances and back-up center identification), and
- Aero-medical access to and from SFGH.

Identified Gaps and Critical Issues

In the critique and discussion of the new Plan, the SFGH Trauma Center leaders identified the following system gaps and critical issues, which must be addressed in an inclusive trauma system design for the City and County:

1. What is the plan for caring for a critically injured infant in San Francisco since there is no Pediatric Trauma Center in SF or within a reasonable (i.e. 15-20 minute) ground transport time of SFGH ?
2. What is the plan for responding to sudden and unexpectedly large numbers of major and minor trauma patients arriving at SFGH either from one event or a number of events within a short period of time? What is the "back-up" plan in this system when SFGH can no longer accept additional trauma patients due to plant disruption, patient overload or multicasualty incident?
3. What is the plan for insuring that all victims of major injury in SF receive optimal trauma care? How are major trauma patients assured of appropriate transfer to SFGH? How will this be monitored and enforced? How is the quality of care assessed for major trauma patients retained at community hospitals in SF (i.e., non-trauma centers)?
4. In the event of a mass casualty event either in SF or neighboring counties (i.e., San Mateo and Marin), how will critical patients be transferred in or out?
5. How will SF participate in regional trauma care and serve the Bay Area (regional) needs for Level 1 services?
6. How will the possible need for emergency air medical transport capability be evaluated for SF? What data will be necessary? What consultants will be retained? What local constraints will be considered and evaluated?

ANNOUNCEMENTS

SFGH staff appreciation day

In thanking all of our staff for their hard and dedicated work, SFGH and UCSF will be sponsoring a staff appreciation day at SFGH on April 18th. All staff will be invited to the Main Cafeteria on April 18th from 2:00 to 3:30 p.m. for cake and ice cream. Administrators and managers will be serving all of the staff who attends.

- 5) **PATIENT CARE REPORT**
(Sue Currin, R.N., Chief Nursing Office)

Ms. Currin presented the attached report (Attachment A).

- 6) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Fannie Lee, Finance Analyst, SFGH)

On behalf of Monique Zmuda, Ms. Lee submitted the Statement of Revenue and Expenses ending March 30, 2001, and the Summary Statistical Information ending March 30, 2001, (Attachment B).

- 7) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**

None.

- 8) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**

None.

The Committee went into Closed Session at 5:05 p.m.

Individuals present in the Closed Session were the same as in the Open Session, except for Fanny Lee.

- 9) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 14641; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

Action Taken: The Committee approved the Closed Session minutes of March 13, 2001

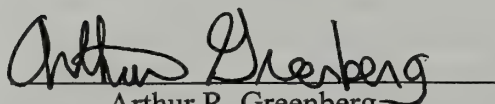
**CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE,
QUALITY ASSURANCE AND CREDENTIALING MATTERS**

The Committee came out of Closed Session at 5:23 p.m.

- 10) **RECONVENE IN OPEN SESSION**

Action Taken: The Committee voted not to disclose any discussions held in Closed Session, (San Francisco Administrative Code Section 67.12(a)).

The meeting was adjourned at 5:30 p.m.


Arthur R. Greenberg
Interim Health Commission Secretary

Attachments (2)



PATIENT CARE REPORT

Joint Conference Committee- San Francisco General Hospital

April 10, 2001

Susan Currin, RN, MSN

Chief Nursing Officer

VACANCY RATES

	Acute Care 4/4/01	Psych 4/4/01	MHRF 4/4/01
RN	6%	15.4%	10%
LVN/LPT	13%	18%	21%

Note: There are new hire RNs and LVNs in progress for 4B, 7D, and Psych that are not counted in these vacancies as they are still being processed.

NURSING RECRUITMENT AND RETENTION ACTIVITIES

SFGHMC's current recruitment efforts are being focused on the development of a master recruitment plan. The plan will incorporate recommendations from multiple nursing workforce shortage reports including the most recently released reports from the National Association of Public Hospitals (NAPH) and the UCSF Center for Education. By analyzing vacancy data, identifying the profile of the SFGHMC nurse candidates for recruitment, examining recruitment and hiring inefficiencies, and incorporating workforce trends, the recruitment plan will provide a template for SFGHMC to meet the challenges of the current nursing shortage.

In addition to developing the master recruitment plan, we continue to research opportunities in housing, childcare, and expansion of educational opportunities for nurses. Through the Hospital Council, SFGH is working on two related initiatives: (1) through a housing task force, looking into housing opportunities at Treasure Island and (2) through an education task force, exploring opportunities for collaboration between San Francisco hospitals and colleges. In addition to these two initiatives, SFGH has also participated with the Hospital Council in the "School to Career Partnership Networking Day" for high school teachers.

The program links teachers with hospital resources in an effort to encourage high school students to enter health care careers.

As reported in the last Patient Care Report, we are still pursuing H1-B visas to be able to recruit more nurses. We have completed two applications for H1-B visas for both an ER nurse from New Zealand and a medical-surgical nurse from Spain. In addition these two nurses, we have 10 other nurses who are very interested in working at SFGH and are currently collecting the necessary documents to process an H1-B visa.

Lastly, our training programs have proven very effective in recruiting nurses. Training programs are being planned for all specialty areas including Medical Surgical, Acute and Long-term Psychiatry/Mental Health, the Emergency Department, Critical Care, and the Operating Room. In Critical Care's training program, 12 nurses are expected to complete their program by mid-June. As spring graduation approaches for many Bay Area colleges and universities, SFGH nursing will continue to try to recruit new graduates by being present at all career fairs.

IMPLEMENTATION OF THE NEW RESTRAINTS POLICY & PROCEDURE

The revised policy and procedure for restraints was implemented in late February. Training on the new policy and procedure was offered to all areas that utilize restraints. The Nursing Quality Improvement Committee is working with Quality Management to design and implement the ongoing process of restraint monitoring. Restraint utilization will be monitored in all patient care areas to track restraint usage and identify indicators that may require further study. In addition, compliance with the policy will also be monitored. The use of restraint protocols for specific patient conditions (i.e. head trauma) is being explored in order to maximize nurses' scope of practice and promote quality patient outcomes.

CHANGE IN THE RAPE TREATMENT CENTER PROGRAM MODEL

On February 26, 2001, the Rape Treatment Center implemented a new model of care for adult victims of sexual assault. The provider staff now consists of 5 Nurse Practitioners and 1 Physician Assistant on site at the Rape Treatment Center and/or the Emergency Department 24 hours/7 days a week. In addition to this change, providers implemented a Universal Screening tool for Intimate Partner Violence, and are now part of the medical care team for identified domestic violence cases in the Emergency Department. The staff continues to perform medical follow-up for clients, and has experienced an increased return rate of follow-up visits by clients in comparison to when the previous model was in place.

OZANAM PROGRAM UPDATE:

The Ozanam Program is a community-based 20 bed Level II/III medically assisted detoxification program, housed in the St. Vincent DePaul social detoxification program at 1175 Howard Street in San Francisco. The program is a joint Community Substance Abuse Services (CSAS)/UCSF project and has the primary focus of providing detoxification services to substance dependent patients while facilitating continued medical, psychiatric, and substance treatment as appropriate. This program is staffed by a multi-disciplinary team including a Medical Director/physician, registered nurses, LVNs, licensed psychiatric technicians, program aides, and a nurse practitioner. Staff are currently being oriented and recruitment efforts are in progress to fill the remaining vacancies.

ANNOUNCEMENTS

Proposed Nurse-Staffing Ratios

Assembly Bill (AB) 394 was enacted in 1999 and requires the California State Department of Health Services (DHS) to adopt a minimum nurse-to-patient ratio for 13 different categories of hospitals by 1/1/02. Various organizations, including the California Healthcare Association (CHA) and the California Nurses Association (CNA), have submitted their proposed ratios for consideration by DHS. CHA recommends that staffing ratios be coupled with the acuity system. The main concern of majority of hospitals is that the minimum staffing ratios will further exacerbate the current effects of the nursing shortage. We will be following the developments closely to determine the possible impact the proposed minimum staffing ratio will have on SFGH.

Change in Nursing Leadership of Perinatal Services

Effective on March 26, 2001, Joseph Pendon, Director of Nursing for Medical Surgical units will also provide leadership for the Perinatal Services provided on the 6C-Birth Center and the 6H- Nursery. We are currently in the process of recruiting for a permanent Nurse Manager for the Birth Center who will oversee the unit's operations and major initiatives (i.e. mother-baby care and breastfeeding).

Nurse Week activities

On May 8th, in honor and recognition of all SFGH nursing staff, the Nursing Department will be sponsoring an ice cream social. The nursing management team will scoop ice cream and make sundaes for staff on all shifts. In addition to the ice cream, there will be prizes awarded at the door.

DIVERSION

The Emergency Department [ED] recorded 40 episodes of diversion for 178 hours representing a rate of 23.5% for March 2001. This is a 5.5% decrease in diversion since February 2001.

The 43 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	Change from previous month
Total diversion	36	167	22%	4% decrease
Trauma over-ride	4	11	1.5%	1.5% decrease

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 172 patients were awaiting admission to in-patient beds [ICU-14, 4B/StepDown-54, MedSurg-104]. In March of 2000, the ED was on diversion 25.6% of the month. Trauma Override was invoked 0.8% of the month in March 2000.

Total diversion was recorded for 36 episodes, a total of 167 hours or a 22 % rate for March 2001. This is a 4 % decrease in total diversion from February 2001.

Trauma override was recorded for 4 episodes, a total of 11 hours or a 1.5 % rate for March 2001. This is a 1.5 % decrease in trauma override from February 2001. While on Trauma override the ED held 36 patients awaiting inpatient beds.

San Francisco General Hospital
Emergency Department
March 2001
Total Diversion Summary

In March, the Emergency Department recorded 36 episodes of Total Diversion
for 167 hours, a percentage of 22 % for the month.

Date	Length	Summary of Event
3/1/01	1710-2310	33 patients in the ED Admits: 1-ICU, 1-Floor ED Waiting room: 5 Urgent patients
3/2/01	1345-1450	28 patients in the ED Admits: 2 ED Waiting room: 6-Urgent patients
3/2/01	1530-1850	28 patients in the ED
3/4/01	1750-1900	38 patients in the ED Admits: 1-4B, 4-Floor ED Waiting room: 10-Urgent patients
3/4/01	2235-0110	30 patients in the ED Admits: 1-ICU, 1-4B, 1-Floor ED Waiting room: 16-Urgent patients
3/5/01	1315-1330	48 patients in the ED Admits: 4 ED Waiting room: 10-Urgent patients
3/6/01	2015-0030	27 patients in the ED Admits: 1-ICU, 2-4B ED Waiting room: 6-Urgent patients
3/7/01	0010-0250	36 patients in the ED Admits: 3-4B, 2-Floor ED Waiting room:
3/7/01	1155-2100	32 patients in the ED ED Waiting room: 3-Urgent patients
3/9/01	2140-0130	37 patients in the ED Admits: 1-ICU, 4-4B, 2-Floor ED Waiting room: 7-Urgent patients
3/10/01	1915 - 2120	26 patients in the ED Admits: 4 ED Waiting room: 6 Urgent patients
3/11/01	0015-0330	37 patients in the ED Admits: 1-ICU, 1-4B, 6-Floor ED Waiting room: 10-Urgent patients

3/23/01	2000-0305	28 patients in the ED Admits: 3-4B, 1-Floor ED Waiting room: 1-Urgent patient
3/24/01	2200-2245	28 patients in the ED Admits: 1-ICU, 2-Floor ED Waiting room: 4-Urgent patients
3/25/01	0130-0500	30 patients in the ED Admits: 2-4B
3/25/01	1500-2155	36 patients in the ED Admits: 2-ICU, 3-Floor ED Waiting room: 8 Urgent patients
3/26/01	2140-0340	37 patients in the ED Admits: 4-4B, 3-Floor ED Waiting room: 10-Urgent patients
3/29/01	0100-0500	29 patients in the ED Admits: 2-4B, 2-Floor ED Waiting room: 11-Urgent patients
3/29/01	1950-0445	29 patients in the ED Admits: 1-Floor ED Waiting room: 9-Urgent patients
3/31/01	1830-2020	32 patients in the ED Admits: 3 admits ED Waiting room: 1-Urgent patient

San Francisco General Hospital
Emergency Department
March 2001
Trauma Override Summary

The Emergency Department recorded 4 episodes of Trauma Override for 11 hours, a percentage of 1.5 % for the month of March.

Date	Length	Summary of Event
3/5/01	1400-1730	911-1 912-4
3/11/01	2030-2130	911-1 912-3
3/12/01	1930-0030	911-1 912-3
3/19/01	1515-1650	912-2

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES
MARCH 2001
(In Thousands of Dollars)

Line No.	MONTH-TO-DATE						ANNUAL					
	Actual	Budget	Fav/(Unfav) Variance	% Var	Prior Year		Projection	Budget	Fav/(Unfav) Variance	% Var	Prior Year	
						GROSS PATIENT REVENUE:						
1	13,564	13,903	(338)	-2%	14,482	Inpatient Medi-Cal Revenue	155,545	162,186	(6,642)	-4%	150,619	1
2	4,529	4,345	184	4%	4,360	Outpatient Medi-Cal Revenue	49,769	50,683	(915)	-2%	47,210	2
3	5,353	4,795	558	12%	5,400	Inpatient Medicare Revenue	60,067	55,937	4,130	7%	54,766	3
4	2,257	1,914	343	18%	2,117	Outpatient Medicare Revenue	22,573	22,334	239	1%	21,725	4
5	10,516	6,973	3,543	51%	6,157	Inpatient Other Revenue	103,314	81,339	21,975	27%	83,296	5
6	5,852	4,977	875	18%	5,375	Outpatient Other Revenue	60,704	58,056	2,648	5%	59,349	6
7	<u>42,071</u>	<u>36,906</u>	<u>5,165</u>	<u>14%</u>	<u>37,891</u>	TOTAL PATIENT SERVICE REVENUE	<u>451,971</u>	<u>430,535</u>	<u>21,435</u>	<u>5%</u>	<u>416,965</u>	7
						REVENUE DEDUCTIONS:						
8	11,997	6,000	(5,997)	-100%	1,207	Charity Care	75,043	70,000	(5,043)	-7%	58,268	8
9	7,782	12,855	5,074	39%	13,132	Provision for Medi-Cal Adjustments	154,814	149,972	(4,842)	-3%	149,060	9
10	5,077	2,400	(2,677)	-112%	2,671	Provision for Medicare Adjustments	33,927	28,000	(5,927)	-21%	27,475	10
11	7,146	4,154	(2,991)	-72%	8,080	Provision for Other Adjustments	50,579	48,463	(2,116)	-4%	53,287	11
12	1,917	1,917	(0)	0%	2,726	Provision for Bad Debt	23,000	23,000	0	0%	23,598	12
13	<u>33,919</u>	<u>27,327</u>	<u>(6,592)</u>	<u>-24%</u>	<u>27,816</u>	TOTAL REVENUE DEDUCTIONS	<u>337,362</u>	<u>319,435</u>	<u>(17,928)</u>	<u>-6%</u>	<u>311,688</u>	13
14	<u>8,153</u>	<u>9,579</u>	<u>(1,427)</u>	<u>-15%</u>	<u>10,075</u>	NET PATIENT SERVICE REVENUE	<u>114,608</u>	<u>111,101</u>	<u>3,508</u>	<u>3%</u>	<u>105,277</u>	14
						OTHER OPERATING REVENUE:						
15	1,038	663	375	57%	523	Capitation	8,459	7,959	500	6%	6,248	15
16	388	388	0	0%	308	Short Doyle	4,654	4,654	0	0%	5,359	16
17	704	704	0	0%	704	MHRF Funding	8,453	8,453	0	0%	8,453	17
18	10,626	10,626	0	0%	3,884	SB855	127,518	127,518	0	0%	91,373	18
19	1,833	1,808	25	1%	(14,558)	SB1255	22,000	21,700	300	1%	21,700	19
20	108	108	0	0%	(5,025)	GME	1,300	1,300	0	0%	1,300	20
21	830	0	830	#DIV/0!	0	Rev from other city departments	9,960	9,960	0	0%	9,654	21
22	0	0	0	#DIV/0!	(629)	Prior Year Settlement	0	0	0	#DIV/0!	(667)	22
23	667	292	375	129%	996	MAA & Other Net Patient Revenue	4,000	4,275	(275)	-6%	4,363	23
24	<u>16,195</u>	<u>14,590</u>	<u>1,605</u>	<u>11%</u>	<u>(13,797)</u>	OTHER OPERATING REVENUE	<u>186,344</u>	<u>185,819</u>	<u>525</u>	<u>0%</u>	<u>147,783</u>	24
25	<u>24,348</u>	<u>24,170</u>	<u>178</u>	<u>1%</u>	<u>(3,722)</u>	TOTAL OPERATING REVENUE	<u>300,952</u>	<u>296,920</u>	<u>4,032</u>	<u>1%</u>	<u>253,060</u>	25
						OPERATING EXPENSES:						
26	12,788	13,227	439	3%	13,134	Personnel Services	154,092	151,158	(2,934)	-2%	148,920	26
27	2,534	3,018	484	16%	3,181	Mandatory Fringe Benefits	36,561	34,490	(2,071)	-6%	35,819	27
28	8,294	8,410	116	1%	6,044	Contractual Services	99,182	101,782	2,600	3%	85,717	28
29	2,148	2,148	0	0%	1,781	Materials and Supplies (Excl. Pharmaceuticals)	25,775	25,775	0	0%	22,433	29
30	1,100	1,000	(100)	-10%	1,258	Pharmaceuticals	14,190	12,000	(2,190)	-18%	14,956	30
31	507	382	(124)	-33%	611	Facilities Maint. & Capital Outlay	6,121	6,121	0	0%	1,385	31
32	1,207	1,245	38	3%	1,417	Services of Other Departments	14,480	14,938	458	3%	13,251	32
33	(106)	(936)	(830)	89%	(907)	Expenditure Recovery	(1,272)	(1,272)	0	0%	(927)	33
34	8,185	8,185	0	0%	8,185	Operating Transfer Out	98,225	98,225	0	0%	63,914	34
35	187	187	0	0%	133	Intrafund Transfer	2,248	2,248	0	0%	1,590	35
36	0	0	0	#DIV/0!	(20,000)	SB1255 & GME IGT	0	0	0	#DIV/0!	0	36
37	(160)	428	587	137%	278	Projects	4,348	4,348	0	0%	1,890	37
38	<u>36,685</u>	<u>37,295</u>	<u>610</u>	<u>2%</u>	<u>15,115</u>	TOTAL OPERATING EXPENSES	<u>453,949</u>	<u>449,813</u>	<u>(4,136)</u>	<u>-1%</u>	<u>388,947</u>	38
39	<u>(12,337)</u>	<u>(13,125)</u>	<u>788</u>	<u>6%</u>	<u>(18,837)</u>	OPERATING INCOME/(LOSS)	<u>(152,997)</u>	<u>(152,893)</u>	<u>(104)</u>	<u>0%</u>	<u>(135,887)</u>	39
						NON-OPERATING REVENUE:						
40	6,053	5,925	128	2%	9,200	General Fund	72,637	72,637	0	0%	65,350	40
41	5,093	5,093	(0)	0%	4,818	Realignment	61,113	61,113	0	0%	58,733	41
42	317	312	5	2%	496	Prop 99	3,807	3,722	84	2%	6,101	42
43	212	205	7	3%	(7,269)	Transfer In	2,547	2,547	0	0%	2,265	43
44	250	836	(586)	-70%	792	Carryforward	9,270	9,270	0	0%	0	44
45	79	87	(8)	-9%	86	Cafeteria	770	1,039	(269)	-26%	877	45
46	246	214	32	15%	295	Miscellaneous	2,952	2,565	387	15%	2,905	46
47	<u>12,250</u>	<u>12,672</u>	<u>(421)</u>	<u>-3%</u>	<u>8,420</u>	NON-OPERATING REVENUE	<u>153,095</u>	<u>152,893</u>	<u>202</u>	<u>0%</u>	<u>136,231</u>	47
48	<u>(87)</u>	<u>(454)</u>	<u>367</u>		<u>(10,417)</u>	NET INCOME/(LOSS)	<u>98</u>	<u>(0)</u>	<u>98</u>		<u>344</u>	48

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION
MARCH 2001

Line No.	CURRENT MONTH					KEY VOLUME INDICATORS	YEAR-TO-DATE				
	Actual	Budget	Variance	% Var	Prior Year		Actual	Budget	Variance	% Var	Prior Year
						Acute Activity					
1	1,422	1,677	(255)	-15%	1,677	Discharges	13,261	14,740	(1,479)	-10%	14,740
2	2,033	2,411	(378)	-16%	2,440	Adjusted Discharges	18,709	21,192	(2,483)	-12%	21,137
						Average Daily Census					
3	183	183	0	0%	196	Acute Med/Surg ADC	191	183	8	5%	198
4	90	92	(2)	-2%	98	Psych ADC	92	93	(1)	-1%	95
5	26	20	6	28%	21	Skilled Nursing ADC	22	22	0	0%	23
6	299	295	4	1%	314	Subtotal ADC Excl. MHRF	305	298	7	2%	316
7	139	140	(1)	-1%	134	MHRF ADC	135	140	(5)	-3%	129
8	438	435	3	1%	448	Subtotal Adult ADC	440	438	3	1%	445
9	8	7	1	18%	10	Nursery ADC	7	7	(0)	-3%	13
10	6.6	5.5	(1.1)	-20%	5.9	Average Length of Stay (excl. MHRF)	6.4	5.6	(0.8)	-15%	5.9
11	1,296	1,295	0.0	0%	1,302	Medicare Case Mix Index	1,296	1,295	0.0	0%	1,302
						Payor Mix (Gross Revenue)					
12	43%	49%	-6%		50%	Medi-Cal	44%	49%	-5%		49%
13	18%	18%	0%		20%	Medicare	18%	18%	0%		19%
14	39%	32%	7%		30%	Other	37%	32%	5%		33%
15	100%	100%	0%		100%	Total	100%	100%	0%		100%
						Patient Days					
16	5,211	5,570	(359)	-6%	6,157	Medi-Cal Patient Days (excl. MHRF)	44,131	49,608	(5,477)	-11%	53,330
17	1,936	1,948	(12)	-1%	2,136	Medicare Patient Days (excl. MHRF)	19,051	17,331	1,720	10%	17,877
18	2,121	1,627	494	30%	1,456	Other Patient Days (excl. MHRF)	20,603	14,676	5,927	40%	15,701
19	9,268	9,145	123	1%	9,749	Total Patient Days (excl. MHRF)	83,785	81,616	2,169	3%	86,908
20	5,221	6,417	(1,196)	-19%	7,177	Medi-Cal Patient Days (incl. MHRF)	49,211	57,094	(7,883)	-14%	60,638
21	1,936	1,972	(36)	-2%	1,807	Medicare Patient Days (incl. MHRF)	19,051	17,549	1,502	9%	17,941
22	6,417	5,095	1,322	26%	4,916	Other Patient Days (incl. MHRF)	52,897	45,333	7,564	17%	43,683
23	13,574	13,485	89	1%	13,900	Total Patient Days (incl. MHRF)	121,159	119,976	1,183	1%	122,262
25	19,402	19,387	15	0%	20,227	Adj. Patient Days	170,959	172,488	(1,530)	-1%	175,325
26	30%	30%	0%	-1%	31%	Outpatient Charges as a % of Total Charges	29%	30%	-1%	-4%	31%
27	82%	81%	1%	1%	83%	% Occupancy (available beds)	82%	82%	0%	1%	83%
						KEY OPERATIONAL INDICATORS					
						Labor					
28	2,347	2,296	(51)	-2%	2,391	FTEs - Productive	2,263	2,296	34	1%	2,349
29	218	313	95	30%	242	FTEs - Non-Productive	339	313	(26)	-8%	335
30	2,566	2,610	44	2%	2,633	FTEs - Total	2,602	2,610	7	0%	2,684
31	334	334	0	0%	351	UC Non-Academic FTEs	334	334	0	0%	351
32	2,900	2,944	44	1%	2,984	Total FTEs	2,936	2,944	7	0%	3,035
33	4.6	4.7	0.1	2%	4.6	FTEs Per AOB (incl. UC)	4.7	4.7	(0.0)	-1%	4.6
34	\$60,147	\$57,700	(2,447)	-4%	\$56,233	Labor Cost per FTE	\$59,114	\$57,911	(1,203)	-2%	\$56,102
35	20%	23%	3%	13%	24%	Fringe Benefits as % of Salary	23%	23%	0%	-2%	23%
36	320	227	93	41%	274	Vacancy positions	320	227	93	41%	274
						Revenues					
37	\$1,255	\$1,247	\$8	1%	(\$184)	Oper. Revenue per adj. Pat. Day	\$1,301	\$1,255	\$46	4%	\$1,171
38	\$607	\$600	\$7	1%	\$592	Oper. Rev. (excl. SB855/1255/GME)/APD	\$639	\$600	\$40	7%	\$536
39	\$11,979	\$10,025	\$1,954	19%	(\$1,525)	Oper. Revenue per adj. Discharge	\$11,889	\$10,212	\$1,677	16%	\$9,713
40	\$5,795	\$4,822	\$973	20%	\$4,908	Oper. Rev. (excl. SB855/1255/GME)/adj. Discharge	\$5,843	\$4,882	\$961	20%	\$4,443
						Expenses					
41	\$1,891	\$1,924	\$33	2%	\$747	Operating Exp. Per adj. Pat. Day	\$1,979	\$1,900	(\$79)	-4%	\$1,800
42	\$1,469	\$1,501	\$33	2%	\$1,331	Operating Exp.(excl. IGT)/adj. Pat. Day	\$1,548	\$1,472	(\$76)	-5%	\$1,375
43	\$18,049	\$15,469	(\$2,580)	-17%	\$6,194	Operating Exp. Per adj. Discharge	\$18,080	\$15,457	(\$2,623)	-17%	\$14,931
44	\$14,021	\$12,074	(\$1,948)	-16%	\$11,035	Operating Exp.(excl. IGT)/adj. Discharge	\$14,142	\$11,979	(\$2,164)	-18%	\$11,403
45	40%	33%	-7%	-21%	30%	Supply Exp. as % of net Pt. Rev.	36%	33%	-3%	-8%	38%
46	98	120	22	18%	126	Days Revenue in Accounts Receivable	98	120	22	18%	126

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, May 8, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

MAY - 7 2001

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: CONSIDERATION OF APPROVING THE MINUTES FOR APRIL 10, 2001
**Minutes of April 10, 2001*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
**Report*

- 5) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Monique Zmuda, DPH Chief Financial Officer)
**Report*
- 6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**
- 7) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**
- 8) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 1461; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF APRIL 10, 2001

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

9) RECONVENE IN OPEN SESSION

ACTION ITEM: VOTE TO ELECT WHETHER TO DISCLOSE ANY OR ALL DISCUSSIONS HELD IN CLOSED SESSION (SAN FRANCISCO ADMINISTRATIVE CODE SECTION 67.12(A))

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

Disability Access

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American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

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Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine

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AGENDA

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JUN 12 2001

JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

SAN FRANCISCO
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Tuesday, June 12, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

- 1) **CALL TO ORDER**
- 2) **PROPOSED ACTION:** **CONSIDERATION OF APPROVING THE MINUTES FOR APRIL 10, 2001. (The May meeting was cancelled)**
**Minutes of April 10, 2001*
- 3) **FOR DISCUSSION:** **HOSPITAL HEALTHCARE UPDATE**
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) **FOR DISCUSSION:** **PATIENT CARE REPORT**
(Sue Currin, RN, Chief Nursing Office)
**Report*

- 5) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
**Report*

- 6) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**

7) CLOSED SESSION

- A) Public Comments on All Matters Pertaining to the Closed Session**
- B) Vote on Whether to Hold a Closed Session (San Francisco Administrative Code Section 67.11(a).)
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: TO APPROVE CLOSED SESSION MINUTES OF APRIL 10, 2001

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

D. Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.14(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.14(a).) (Action Item)

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

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MINUTES

JOINT CONFERENCE COMMITTEE MEETING FOR SAN FRANCISCO GENERAL HOSPITAL

Tuesday, June 12, 2001
3:45 p.m.
1001 Potrero Avenue, Room #2A6
San Francisco, CA 941102

DOCUMENTS DEPT.

JUL 19 2001

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1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order by Commissioner Lee John I. Umekubo, M.D., at 3:45 p.m.

Present: Commissioner Lee Ann Monfredini

Absent: Commissioner John I. Umekubo, M.D.

Staff: Sue Currin, Melinda Garcia, Alan Gelb, MD, Fred Hom, Philip Hopewell, MD, Mitchell Katz, MD, Mozettia Hanley, Jerolyn Navarro, MD, Gene O'Connell, RN, Gregg Sass, Hiroshi Tokubo, and Chris Wachsmuth

2) APPROVAL OF MINUTES OF THE JCC-SFGH MEETING OF APRIL 10, 2001

Action Taken: The Committee adopted the minutes of April 10, 2001.

3) HOSPITAL HEALTHCARE UPDATE (Gene O'Connell, Executive Administrator,

SFGH Receives NAPH Award for Integrated Soft Tissue Infection Service

Ms. O'Connell announced that San Francisco General Hospital's Integrated Soft Tissue Infection Service (ISIS) has received honorable mention award from the National Association of Public

Hospitals (NAPH) in the category of the safety net health innovation. Over 26 public hospitals across the nation submitted nominations for consideration for three award categories. San Francisco General Hospital will receive the honorable mention award at this year's NAPH conference in Santa Fe on June 28th. Ms. O'Connell will be in attendance at the conference to accept on San Francisco General Hospital's behalf.

Congratulations to the ISIS Team: Gayling Gee, Associate Administrator for Specialty and Diagnostics; Hobart Harris, Co-Medical Director for ISIS; David Young, Co-Medical Director for ISIS; and Jacquie Caesar, ISIS Clinic Nurse Manager for their outstanding work in ISIS and for receiving an honorable mention award from NAPH.

World Birthday Film Project

SFGH's Birth Center is honored to be participating in the New York Times/Granada Television produced *World Birthday* film project. *World Birthday* is a documentary that will show births and first days of life of babies born in nine countries worldwide. UCSF/SFGH babies will represent the United States. The documentary will document the birth of the babies (of consenting families) and the babies' care in the first few days following the birth. Filming will take place on July 2nd and 3rd and is planned to air in January 2002.

SFO Airport Medical Clinic Transition

Since 1995, the UCSF Department of Medicine at SFGH has managed and provided direct patient care service at the SFO Medical Service (outpatient clinic located at San Francisco International Airport). The SFO Medical Service provides travel medicine services, urgent care, primary care, employee health, workers' compensation services, and medical surveillance services for airport employees, travelers, SFO tenants as well as other clients and businesses in the SF Airport community.

UCSF in consultation with SFGH made the decision to terminate the contract with the Airport effective May 31, 2001. The Airport Director, Commission and Civil Service Commission approved a proposal by Catholic Healthcare West/St. Mary's Hospital to become the provider of Airport Medical Services effective June 1, 2001. A planning team composed of leaders from SFO Medical Services, UCSF Department of Medicine and SFGH Administration has met weekly since February to ensure the successful transition to CHW management. SFO Medical Service is now a licensed outpatient clinic of St. Mary's Hospital in San Francisco.

The UCSF Department of Medicine/SFGH in conjunction with SFGH administration and Medical Records Department will continue to work with CHW after June 1 to ensure an effective and efficient transition with minimal disruption to patient care services.

Transition services that SFGH/UCSF will be providing to the SFO Medical Service include:

- management of accounts receivable activities for professional fee billings (initiated during UCSF management),
- management of accounts payable activities (initiated during UCSF management)
- oversight of designated administrative and management staff reimbursement of the related payroll expenses and coordination of Federal Aviation Administration (FAA) claims processing services, and
- custodian of approximately 40,000 medical records from the first 5 years of clinic operation.

SFO will fund all costs associated with the transition services that SFGH/UCSF have agreed to provide.

JCAHO Preparation Update

San Francisco General Hospital Medical Center is moving forward with preparing for the 2002 Annual Survey. As part of the preparation, a Special Events workgroup has been charged to implement activities to further educate and engage staff in JCAHO preparation. The workgroup has already set a date for a "kick-off" event on June 12th that will include games related to hospital policies and procedures and prizes. The event will be held in the main hallway of the 2nd floor from 11:00 a.m. to 2:00 p.m.

In addition, a consultant, through the RFQ process, has been selected to provide mock survey services so that SFGHMC can better identify areas needing improvement. This will aid SFGH in preparing for the overall Consolidated Accreditation and Licensure Survey (CALs) as well as the JCAHO Clinical Laboratories Survey that is tentatively scheduled for October 2001.

As preparations progress, SFGH will continue to inform you of the activities.

JCAHO Sentinel Event Interview

On May 2, 2001, the Special Survey Unit of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) notified Gene O'Connell's office that JCAHO had received an unsigned letter reporting two sentinel events that had occurred at SFGH. In accordance with JCAHO's Sentinel Event Policy, SFGH was asked to provide evidence that the hospital had conducted a thorough and comprehensive root cause analysis of one of the events, which had had a fatal outcome.

Both of the involved cases had already been reviewed and presented to SFGH JCC. Because of the legal protections of California Evidence Code 1157, SFGH made a decision not to submit its protected root cause analysis and action plans to JCAHO. On May 30, 2001, a team of SFGH staff and physicians personally presented the root cause analysis to Ms. Jill Egger, JCAHO Sentinel Event Specialist.

Ms. Egger conducted the meeting from an educational perspective. She reacted favorably to the depth and breadth of the root cause analysis and the quality of our significant/ sentinel event review process. A six-month follow-up report summarizing the status of action plan items will be required.

Annual Medical Staff Dinner

SFGH and the UCSF Dean's Office will be hosting their annual medical staff dinner on June 13, 2001 at 6:00 p.m. This dinner is held in appreciation of all the medical staff's dedication and hard work in providing care to all of SFGH's patients as well as maintaining the academic and research focus of the hospital. This year, Alan Gelb will pass the responsibilities of Chief of Staff to J. Renee Navarro, MD. Ms. O'Connell thanked Alan Gelb for all of his dedication and leadership to the Medical Staff as the Chief of Staff for the past two fiscal years. His leadership was effective in strengthening communication between the Medical and the Administrative Staff.

Pharmacy Update

PBM Update – For the first five months of PBM operation (November 16, 2000 – April 20, 2001), a total of 47,474 prescriptions were filled for uninsured CHN patients by 105 community pharmacies located in San Francisco. The number of community pharmacies participating has steadily increased from 77 in November 2000 to 105 presently. Of the 47,474 prescriptions, 10% were filled by

independent pharmacies, 78% were filled in a Walgreens Pharmacy, and the remainder was filled in other chain pharmacies (e.g. Rite Aid, Safeway, Sav-On.)

Since the inception of the program, the pharmacy at SFGH experienced a drop in total prescription volume of approximately 35% when compared to the average for the months preceding PBM implementation. With the decrease in volume, prescriptions were filled consistently within two hours. Additionally, fifty (50) percent of prescriptions' wait times were one hour or less. A Patient Satisfaction Survey of 100 patients conducted during March 2001 showed that patients have a higher satisfaction rating in many categories of the SFGH OP pharmacy as compared to March 2000. Most significant is 92% of the interviewed had a good to excellent impression of pharmacy as compared to only 56% in March 2000.

TOP 20 HIGHEST DISPENSING PCN PHARMACIES FOR CHN CLIENTS

LOCATION # ON MAP	PHARMACY NAME	ADDRESS	ZIP CODE	# OF PRESCRIPTIONS
1	WALGREENS PHARMACY	1189 POTRERO AVE	94110	6203 (9.0%)
2	WALGREENS PHARMACY	1301 MARKET STREET	94103	3005 (4.3%)
3	WALGREENS PHARMACY	1979 MISSION ST	94103	2490 (3.6%)
4	RITE AID PHARMACY	1496 MARKET STREET	94102	2488 (3.6%)
5	WALGREENS PHARMACY	498 CASTRO ST	94114	2437 (3.5%)
6	WALGREENS PHARMACY	2690 MISSION ST	94110	2149 (3.4%)
7	WALGREENS PHARMACY	5300 3RD ST	94124	1610 (2.3%)
8	WALGREENS PHARMACY	825 MARKET ST	94103	1604 (2.3%)
9	WALGREENS PHARMACY	4645 MISSION ST	94112	1576 (2.3%)
10	WALGREENS PHARMACY	499 HAIGHT ST	94117	1455 (2.1%)
11	WALGREENS PHARMACY	790 VAN NESS AVE	94102	1265 (1.8%)
12	WALGREENS PHARMACY	2494 SAN BRUNO AVE	94134	1247 (1.8%)
13	WALGREENS PHARMACY	3398 MISSION ST	94110	1028 (1.5%)
14	WALGREENS PHARMACY	1344 STOCKTON ST	94133	988 (1.4%)
15	WALGREENS PHARMACY	3801 3RD ST, #550	94124	902 (1.3%)
16	MERRILL'S DRUG CENTER	1091 MARKET STREET	94103	868 (1.3%)
17	WALGREENS PHARMACY	500 GEARY ST	94102	831 (1.2%)
18	WALGREENS PHARMACY	2050 IRVING ST	94122	801 (1.2%)
19	WALGREENS PHARMACY	1363 DIVISADERO ST	94115	744 (1.1%)
20	SAFEWAY PHARMACY	2020 MARKET ST	94114	655 (0.9%)

Pharmaceutical cost containment initiatives – With the pharmaceutical cost projected to increase by 18% for the next fiscal year, pharmacy has been actively pursuing the following initiatives to reduce or maintain the current spending:

1. **Manufacturers' free drug program** – Various manufacturers offer limited free drugs to indigent patients through a laborious documentation system. By streamlining workflow, pharmacy has begun this laborious documentation with limited staffing. The return in investment depends on the staffing dedicated to the program and can potentially save up to \$250,000 or more per fiscal year. Additional staffing will be required to increase the projected annual savings.
2. **Indigent Drug pricing for community pharmacies** – A demonstration project to extend 340B pricing to our PBM pharmacies was submitted from Dr. Katz's office to Office of Pharmacy Affairs (OPA). With support from Congressional representatives, the Office of the Secretary of Health and Human Services has approved and authorized OPA to implement the demonstration project initiative. Pending California legislature and OPA's guidelines, pharmacy will pursue extending 340B drug pricing to our PBM pharmacies. Fiscal impact: Potential savings of up to \$1 million per year.
3. **340B discount drug pricing for hospitalized indigent patients** – Congressional representatives have been contacted to support removing a federal barrier preventing publicly supported disproportional share hospitals like SFGH from negotiating better prices for inpatient pharmaceuticals. Fiscal impact: Potential to save \$1 million per year.

4) **PATIENT CARE REPORT**
(Sue Currin, RN, Chief Nursing Office)

Ms. Currin presented the Patients Care Report, see Attachment A.

5) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Gregg Sass, CHN Chief Financial Officer)

Mr. Sass submitted the Statement of Revenue and Expenses ending May 31, 2001, and the Summary Statistical Information (May 31, 2001), see Attachment B.

6) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL****

None.

7) **PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION**

None.

The Committee went into closed session at 5:00 p.m.

Individuals present in the closed session were the same as in the open session.

8) **CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 14641; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1**

Action Taken: The Committee approved the Closed Session minutes of June 12, 2001

**CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE,
QUALITY ASSURANCE AND CREDENTIALING MATTERS**

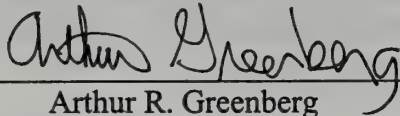
The Committee came out of Closed Session at 5:39 p.m.

9) **RECONVENE IN OPEN SESSION**

Action Taken: The Committee voted not to disclose any discussions held in Closed Session, (San Francisco Administrative Code Section 67.12(a).

10) **AJOURNMENT**

The meeting was adjourned at 5:40 p.m.



Arthur R. Greenberg
Interim Health Commission Secretary

Attachments (2)

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 6/12/01

Sue Currin, RN, MS, Chief Nursing Officer

Nurse Week

Nursing Management is sponsored an ice cream social on May 8, 2001 in recognition of Nurse Week. Nursing Management, Hospital Administration and the Medical Staff honored nurses with a golden lamp of nursing pin, also known as the lamp of knowledge. This symbol is associated with Florence Nightingale who used such a lamp during her pioneering work in the Crimean War. The lamp depicts the care and compassion which nurses give their patients, as well as ongoing learning and pursuit of nursing knowledge. Nurses were also be honored by individual unit/departments at a variety of celebrations during the week.

The DPH Nursing Leadership Council (NLC) and SEIU Local 790 hosted a Nurse Week celebration at the Potrero Brewing Company on May 9, 2001 from 4:00 to 6:30 PM. The theme was "Nurses---the True Spirit of Caring."

Recruitment/Retention Activities

SFGHMC Nursing Management hosted a meeting with SEIU Local 790 on April 25, 2001 to explore grant proposal options for a nurse training program. Representatives from the Department of Labor (DOL) Washington DC and SF offices participated in the discussions along with a representative from AFL-CIO California Labor Federation. We will be working with the local Private Industry Council over the next several months on the grant. The DOL recommended that we explore expansion of the grant to Contra Costa, Alameda, and Santa Clara counties. The DOL may consider regional grants more favorably since the nursing workforce issues are not just unique to San Francisco.

Nurse Research Day 2001

SFGHMC Nursing collaborated with Stanford, VA, UCSFMC and UCSF School of Nursing to sponsor a Nursing Research Conference on innovations in patient care. With over 80 participants in attendance, the program recognized nursing research and quality focused studies in patient care.

Diversion Summary Report

See attached.

San Francisco General Hospital

Diversion Report

MAY 2001

Executive Summary

The Emergency Department [ED] recorded 41 episodes of diversion for 173 hours representing a rate of 23 % for May 2001. This is a 2.0 % decrease in diversion since April 2001.

The 41 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from previous month
Total diversion	36	155	21%	1% decrease
Trauma over-ride	5	18	2%	1% decrease

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 123 patients were awaiting admission to in-patient beds [ICU-14, 4B/StepDown-58, MedSurg-51]. In May of 2000, the ED was on diversion 30% of the month. Trauma Override was invoked 0.2% of the month in May 2000.

Total diversion was recorded for 36 episodes, a total of 155 hours or a 21 % rate for May 2001.

Trauma override was recorded for 5 episodes, a total of 18 hours or a 2 % rate for May 2001. This is a 1.0% decrease in trauma override from April 2001. While on Trauma override the ED held 23 patients awaiting inpatient beds.

Definitions:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSA definitions:

Total diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Pat Nagle R.N.
Base Hospital Coordinator

San Francisco General Hospital
Emergency Department
2001
Trauma Override Summary

The Emergency Department recorded 5 episodes of Trauma Override for 18 hours and 02 min, a percentage of 2.3% for the month of May.

Date	Length	Summary of Event
5/4/01	2350-0650	1 - 912 36 patients in the ED
5/10/01	1725-2050	2 - 911, 2 - 912 34 patients in the ED
5/11/01	2112-2220	1 - 912 42 patients in the ED
5/11/01	2354-0435	1 - 911, 1-912 42 patients in the ED
5/18/01	1800-2000	2 - 911, 3-912 36 patients in the ED

San Francisco General Hospital
Emergency Department
2001
Total Diversion Summary

In May the Emergency Department recorded 36 episodes of Total Diversion for 155 hours and 38 min, a percentage of 21 % for the month of May.

Date	Length	Summary of Event
5/1/01	1600-2100	37 patients in the ED Admits: 1-ICU; 3-4B ED waiting room: 0
5/1/01	2840-0220	28 patients in the ED Admits: 3-4B ED waiting room: 4 urgent patients
5/2/01	1202-2200	37 patients in the ED Admits: 1-ICU ED waiting room: 10 urgent patients
5/4/01	1130-1515	48 patients in the ED Admits: 1-ICU; 1-4B ED waiting room: 0
5/4/01	2340-0900	40 patients in the ED Admits: 1-ICU, 1-4B; 1-Floor ED waiting room: 12 urgent patients
5/5/01	2040-2315	31 patients in the ED Admits: 2-4B, 3-Floor ED waiting room: 0
5/6/01	1455-1725	32 patients in the ED Admits: 0 ED waiting room: 0
5/6/01	1820-0715	42 patients in the ED Admits: 1-4B ED waiting room: 4 urgent patients
5/7/01	1835-0608	38 patients in the ED Admits: 1-4B, 3-Floor ED waiting room: 9 urgent patients
5/9/01	1050-1305	21 patients in the ED (2 intubated pts w/ 1:1 ratio) 1 expires Admits: 2-ICU, 4-4B ED waiting room: 0
5/11/01	1205-1500	47 patients in the ED Admits: 2-ICU, 3-4B ED waiting room: 0
5/11/01	2117-2220	38 patients in the ED Admits: 1-ICU, 2-4B, 4-Floor ED waiting room: 10 urgent patients
5/12/01	2100-0130	26 patients in the ED Admits: 1-4B ED waiting room: 3 urgent patients
5/13/01	2055-0255	36 patients in the ED Admits: 1-ICU, 6-4B, 4-Floor ED waiting room: 6 urgent patients
5/14/01	0910-1610	41 patients in the ED Admits: 0 ED waiting room: 0
5/14/01	2350-0245	36 patients in the ED Admits: 1-4B, 2-Floor ED waiting room: 6 urgent patients

5/15/01	1845-2115	33 patients in the ED Admits: 0 ED waiting room: 0
5/16/01	0155-0600	32 patients in the ED Admits: 1-4B, 2-Floor ED waiting room: 6 urgent patients
5/16/01	1420-2100	48 patients in the ED Admits: 1-Floor ED waiting room: 5 urgent patients
5/17/01	1330-1520	42 patients in the ED Admits: 2-4B, 3-Floor (Isol./custody) ED waiting room: 0
5/17/01	1630-1955	33 patients in the ED Admits: 1-4B, 5-Floor ED waiting room: 6 urgent patients
5/18/01	1555-2000	32 patients in the ED Admits: 1-4B, 2-Floor ED waiting room: 2 urgent patients
5/19/01	2315-0424	34 patients in the ED Admits: 1-ICU, 2-4B, 3-Floor ED waiting room: 15 urgent patients
5/20/01	2055-0200	28 patients in the ED Admits: 1-4B ED waiting room: 6 urgent patients
5/21/01	1130-1300	40 patients in the ED Admits: 1-4B, 1-Floor (sitter) ED waiting room: 10 urgent patients
5/21/01	1930-0317	43 patients in the ED Admits: 3-4B ED waiting room: 10 urgent patients
5/22/01	2045-2245	44 patients in the ED Admits: 2-4B, 5-Floor ED waiting room: 0
5/23/01	1545-1845	33 patients in the ED Admits: 2-4B, 2-Floor ED waiting room: 6 urgent patients
5/26/01	0136-0430	32 patients in the ED Admits: 1-ICU (PICU), 5-4B, 2-Floor ED waiting room: 6 urgent patients
5/26/01	1950-0200	29 patients in the ED Admits: 2-ICU ED waiting room: 5 urgent patients
5/27/01	2100-2200	27 patients in the ED Admits: 2-ICU ED waiting room: 0
5/28/01	2250-0250	29 patients in the ED Admits: 2-4B, 2-Floor ED waiting room: 8 urgent patients
5/29/01	1645-2130	34 patients in the ED Admits: 4-4B ED waiting room: 6 urgent patients
5/30/01	1356-1900	29 patients in the ED Admits: 2-4B ED waiting room: 0
5/30/01	2000-2200	32 patients in the ED Admits: 0 ED waiting room: 4 urgent patients
5/31/01	1325-1445	52 patients in the ED Admits: 1-4B ED waiting room: 0

San Francisco General Hospital

Diversion Report

April 2001

Executive Summary

The Emergency Department [ED] recorded 40 episodes of diversion for 177 hours representing a rate of 25 % for April 2001. This is a 1.5 % increase in diversion since March 2001.

The 43 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from previous month
Total diversion	34	158	22%	none
Trauma over-ride	6	19	3%	1.5% increase

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 167 patients were awaiting admission to in-patient beds [ICU-9, 4B/StepDown-72, MedSurg-86]. In March of 2000, the ED was on diversion 24% of the month. Trauma Override was invoked 0.4% of the month in March 2000.

Total diversion was recorded for 34 episodes, a total of 158 hours or a 22 % rate for April 2001.

Trauma override was recorded for 6 episodes, a total of 19 hours or a 3 % rate for April 2001. This is a 1.5 % increase in trauma override from March 2001. While on Trauma override the ED held 51 patients awaiting inpatient beds.

Definitions:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSA definitions:

Total diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Pat Nagle R.N.
Base Hospital Coordinator

San Francisco General Hospital
Emergency Department
April 2001
Total Diversion Summary

In April, the Emergency Department recorded 34 episodes of Total Diversion for 157 hours and 30 min, a percentage of 22 % for the month.

Date	Length	Summary of Event
4/3/01	1530-2100	33 patients in the ED Admits: 1-ICU; 3-4B ED waiting room: 7 Urgent patients
4/4/01	1145-1730	29 patients in the ED Admits: 3-Floor ED waiting room: 7 Urgent patients
4/5/01	1430-1830	31 patients in the ED Admits: ED waiting room:
4/6/01	1825-2125	36 patients in the ED Admits: 2-4B ED waiting room: 13 urgent patients
4/7/01	2110-2255	35 patients in the ED Admits: 3-ICU ED waiting room: 6 urgent patients
4/8/01	0030-0330	26 patients in the ED Admits: 1-ICU; 3-4B ED waiting room: 10 urgent patients
4/8/01	1700-1905	30 patients in the ED Admits: 5-4B ED waiting room: 4 urgent patients
4/9/01	1455-1815	38 patients in the ED Admits: 3-4B; 1-Floor ED waiting room: 3 urgent patients
4/9/01	2115-0015	28 patients in the ED Admits: 7-4B; 1-Floor ED waiting room: 9 urgent patients
4/10/01	1115-1215	32 patients in the ED Admits: 1-ICU; 3-4B ED waiting room:
4/10/01	1610-1518	29 patients in the ED Admits: 2-4B ED waiting room: 4 urgent patients
4/11/01	1145-1715	46 patients in the ED Admits: 1-4B; 1-Floor ED waiting room: 2 urgent patients
4/12/01	1925-2130	28 patients in the ED Admits: 4-4B; 2-Floor ED waiting room: 2 urgent patients
4/13/01	1210-1400	36 patients in the ED Admits: 2-4B; 9-Floor ED waiting room: 3 urgent patients
4/13/01	2000-2400	26 patients in the ED 14 admits ED waiting room: 3 urgent patients
4/14/01	1650-1930	33 patients in the ED Admits: 3-4B; 4-Floor ED waiting room: 5 urgent patients

4/14/01	2240-1015	27 patients in the ED Admits: 4-4B;7-Floor ED waiting room:
4/15/01	0930-1545	29 patients in the ED ADMITS: 2-4B;9-FLOOR ED WAITING ROOM:
4/15/01	1730-0430	36 patients in the ED Admits: 1-4B;7-Floor ED waiting room: 5 urgent patients
4/17/01	1430-1735	31 patients in the ED Admits: 1-ICU ED waiting room:
4/17/01	2005-0200	34 patients in the ED Admits: 4-4B;2-Floor ED waiting room: 6 urgent patients
4/18/01	1450-2200	29 patients in the ED Admits: 2-4B;5-Floor ED waiting room: 6 urgent patients
4/19/01	1835-1945	34 patients in the ED Admits: 2-4B;4-Floor ED waiting room: 12 urgent patients
4/19/01	0215-0930	29 patients in the ED 4 admits ED waiting room: 10 urgent patients
4/20/01	1340-1900	33 patients in the ED Admits: 6-4B ED waiting room: 7 urgent patients
4/20/01	2250-0440	31 patients in the ED Admits: 2-4B,2-Floor w/1 Isolation. ED waiting room: 1 urgent patient
4/23/01	1600-0135	28 patients in the ED Admits: ED waiting room:10 urgent patients
4/24/01	1910-0610	40 patients in the ED Admits: 1-4B;4-Floor ED waiting room: 10 urgent patients
4/25/01	1200-1345	34 patients in the ED Admits: ED waiting room:
4/25/01	1830-0815	No information
4/26/01	1805-2205	28 patients in the ED Admits: 1-ICU;1-4B;3-Floor ED waiting room: 10 urgent patients
4/29/01	1420-1510	26 patients in the ED Admits: 2-Floor ED waiting room:
4/29/01	2000-0015	27 patients in the ED Admits: 1-ICU;1-Floor ED waiting room: 4 urgent patients
4/30/01	1345-1755	36 patients in the ED No other information

San Francisco General Hospital
Emergency Department
April 2001
Trauma Override Summary

The Emergency Department recorded 6 episodes of Trauma Override for 19 hours and 15 min, a percentage of 3 % for the month of April.

Date	Length	Summary of Event
4/2/01	1915-0035	911-1 30-patients in the ED
4/3/01	1920-2110	912-3 32-patients in the ED
4/4/01	1735-2230	912-5, 910-1 28-patients in the ED
4/16/01	1835-0055	912-2 41-patients in the ED
4/18/01	2340-0245	912-6 32-patients in the ED
4/19/01	2215-0215	912-5, 911-1 41-patients in the ED

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/01

Month Ending: MAY 31, 2001
(In Thousands of Dollars)

MONTHLY						ANNUAL					
	Pav/(Unfav)						Pav/(Unfav)				
	Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual
	GROSS PATIENT REVENUE:						GROSS PATIENT REVENUE:				
1	11,724	13,040	(1,316)	-10.1%	9,443	Inpatient Medi-Cal Revenue	153,523	162,187	(8,664)	-5.3%	150,619
2	4,321	4,075	246	6.0%	4,183	Outpatient Medi-Cal Revenue	50,443	50,683	(240)	-0.5%	47,210
3	5,620	4,497	1,123	25.0%	4,130	Inpatient Medicare Revenue	63,000	55,938	7,062	12.6%	54,766
4	2,013	1,796	217	12.1%	1,844	Outpatient Medicare Revenue	23,160	22,334	826	3.7%	21,725
5	11,630	6,539	5,091	77.9%	9,887	Inpatient Other Revenue	116,572	81,338	35,234	43.3%	83,296
6	5,718	4,668	1,050	22.5%	5,148	Outpatient Other Revenue	63,180	58,057	5,123	8.8%	59,349
7											
8	<u>41,026</u>	<u>34,615</u>	<u>6,411</u>	<u>18.5%</u>	<u>34,635</u>	TOTAL PATIENT SERVICE REVENUE	<u>469,878</u>	<u>430,537</u>	<u>39,341</u>	<u>9.1%</u>	<u>416,965</u>
9											
10	REVENUE DEDUCTIONS:						REVENUE DEDUCTIONS:				
11	9,006	5,628	(3,378)	-60.0%	5,777	Charity Care	79,569	70,000	(9,569)	-13.7%	58,268
12	11,923	12,058	135	1.1%	11,624	Provision for Medi-Cal Adjustments	158,567	149,972	(8,595)	-5.7%	149,060
13	3,612	2,251	(1,361)	-60.5%	646	Provision for Medicare Adjustments	41,771	28,000	(13,771)	-49.2%	27,475
14	7,270	3,896	(3,374)	-86.6%	7,549	Provision for Other Adjustments	57,995	48,463	(9,532)	-19.7%	53,287
15	(1,750)	1,917	3,667	191.3%	(631)	Provision for Bad Debt	19,000	23,000	4,000	17.4%	23,598
16	<u>30,061</u>	<u>25,750</u>	<u>(4,311)</u>	<u>-16.7%</u>	<u>24,965</u>	TOTAL REVENUE DEDUCTIONS	<u>356,902</u>	<u>319,435</u>	<u>(37,467)</u>	<u>-11.7%</u>	<u>311,688</u>
17											
18	<u>10,965</u>	<u>8,865</u>	<u>2,100</u>	<u>23.7%</u>	<u>9,670</u>	NET PATIENT SERVICE REVENUE	<u>112,976</u>	<u>111,102</u>	<u>1,874</u>	<u>1.7%</u>	<u>105,277</u>
19											
20	OTHER OPERATING REVENUE:						OTHER OPERATING REVENUE:				
21	705	663	42	6.3%	454	Capitation/Managed Care Settlement	8,459	7,959	500	6.3%	6,248
22	388	388	0	n/a	308	Short Doyle	4,654	4,654	0	n/a	5,359
23	704	704	0	n/a	704	MHRF Funding	8,453	8,453	0	n/a	8,453
24	10,626	10,626	0	n/a	10,626	SB855	127,518	127,518	0	n/a	91,373
25	1,833	1,808	25	1.4%	1,808	SB1255	22,000	21,700	300	1.4%	21,700
26	108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300
27	830	0	830	n/a	0	Revenue from Other City Departments	9,960	9,960	0	n/a	9,654
28	(34)	0	(34)	n/a	(1,179)	Prior Year Settlement	(34)	0	(34)	n/a	(667)
29	333	292	41	14.0%	713	MAA & Other Net Patient Revenue	4,000	4,555	(555)	-12.2%	4,363
30	<u>15,493</u>	<u>14,589</u>	<u>904</u>	<u>6.2%</u>	<u>13,542</u>	TOTAL OTHER OPERATING REVENUE	<u>186,310</u>	<u>186,099</u>	<u>211</u>	<u>0.1%</u>	<u>147,783</u>
31											
32	<u>26,458</u>	<u>23,454</u>	<u>3,004</u>	<u>12.8%</u>	<u>23,212</u>	TOTAL OPERATING REVENUE	<u>299,286</u>	<u>297,201</u>	<u>2,085</u>	<u>0.7%</u>	<u>253,060</u>
33											
34	OPERATING EXPENSES:						OPERATING EXPENSES:				
35	13,704	13,227	(477)	-3.6%	12,868	Personnel Services	154,295	151,334	(2,961)	-2.0%	148,920
36	3,278	3,018	(260)	-8.6%	3,128	Mandatory Fringe Benefits	36,824	34,490	(2,334)	-6.8%	35,819
37	8,365	8,410	45	0.5%	9,973	Contractual Services	99,511	102,111	2,600	2.5%	85,717
38	2,148	2,148	0	n/a	1,930	Materials and Supplies (excl. Pharm.)	25,775	25,775	0	n/a	22,433
39	1,250	1,000	(250)	-25.0%	1,066	Pharmaceuticals	13,219	12,000	(1,219)	-10.2%	14,956
40	517	382	(135)	-35.3%	390	Facilities Maint. & Capital Outlay	6,133	6,133	0	n/a	1,385
41	1,374	1,245	(129)	-10.4%	1,236	Services of Other Departments	16,002	14,987	(1,015)	-6.8%	13,251
42	(106)	(936)	(830)	-88.7%	(945)	Expenditure Recovery	(1,272)	(1,272)	0	n/a	(927)
43	8,185	8,185	0	n/a	8,199	Operating Transfer Out	98,225	98,225	0	n/a	63,914
44	187	187	0	n/a	133	Intrafund Transfer	2,248	2,248	0	n/a	1,590
45	0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0
46	428	428	0	n/a	278	Projects	5,131	5,131	0	n/a	1,890
47	<u>39,330</u>	<u>37,294</u>	<u>(2,036)</u>	<u>-5.5%</u>	<u>38,256</u>	TOTAL OPERATING EXPENSES	<u>456,091</u>	<u>451,162</u>	<u>(4,929)</u>	<u>-1.1%</u>	<u>388,948</u>
48											
49	<u>(12,872)</u>	<u>(13,840)</u>	<u>968</u>	<u>7.0%</u>	<u>(15,044)</u>	OPERATING INCOME/(LOSS)	<u>(156,805)</u>	<u>(153,961)</u>	<u>(2,844)</u>	<u>-1.8%</u>	<u>(135,888)</u>
50											
51	NON-OPERATING REVENUE:						NON-OPERATING REVENUE:				
52	6,053	5,925	128	2.2%	3,742	General Fund	72,637	72,637	0	n/a	65,350
53	5,093	5,093	0	n/a	4,818	Realignment	61,113	61,113	0	n/a	58,733
54	336	312	24	7.7%	508	Prop 99	3,751	3,751	0	n/a	6,101
55	374	205	169	82.4%	2,598	Transfer In and Project-Related	2,723	2,723	0	n/a	2,265
56	821	836	(15)	-1.8%	754	Carryforward	10,034	10,034	0	n/a	0
57	64	87	(23)	-26.4%	91	Cafeteria	772	1,037	(265)	-25.6%	877
58	339	214	125	58.4%	239	Miscellaneous	3,053	2,666	387	14.5%	2,905
59	<u>13,080</u>	<u>12,672</u>	<u>408</u>	<u>3.2%</u>	<u>12,750</u>	TOTAL NON-OPERATING REVENUE	<u>154,083</u>	<u>153,961</u>	<u>122</u>	<u>0.1%</u>	<u>136,231</u>
60											
61	<u>208</u>	<u>(1,168)</u>	<u>1,376</u>	<u>117.8%</u>	<u>(2,294)</u>	NET INCOME/(LOSS)	<u>(2,722)</u>	<u>0</u>	<u>(2,722)</u>	<u>n/a</u>	<u>343</u>

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/01
Month Ending: MAY 31, 2001

CURRENT MONTH						YEAR-TO-DATE					
Actual	Budget	Variance	% Var	Prior Year	KEY VOLUME INDICATORS	Actual	Budget	Variance	% Var	Prior Year	
					<u>Discharges (incl. MHRF)</u>						
1,469	1,567	(98)	-6.3%	1,567	Discharges (incl. MHRF)	16,176	17,770	(1,594)	-9.0%	17,770	
2,080	2,253	(173)	-7.7%	2,313	Adjusted Discharges (incl. MHRF)	22,813	25,547	(2,734)	-10.7%	25,615	
					<u>Average Daily Census</u>						
185	162	23	14.2%	173	Acute Med/Surg ADC	190	179	11	6.1%	193	
92	92	0	n/a	95	Psych ADC	92	93	(1)	-1.1%	95	
25	14	11	78.6%	14	Skilled Nursing ADC	23	21	2	9.5%	22	
302	268	34	12.7%	282	Total ADC excl. MHRF	305	293	12	4.1%	310	
140	140	0	n/a	142	MHRF ADC	137	140	(3)	-2.1%	131	
442	408	34	8.3%	424	Total Adult ADC	442	433	9	2.1%	441	
7	7	0	1.4%	9	Nursery ADC	7	7	0	n/a	12	
6.4	5.3	(1.1)	-20.8%	5.6	Average Length of Stay (excl. MHRF)	6.4	6.0	(0.4)	-6.7%	5.9	
1.304	1.295	0.009	0.7%	1.301	Medicare Case Mix Index	1.304	1.295	0.009	0.7%	1.301	
					<u>Payor Mix (Gross Revenue)</u>						
39.1%	49.4%	-10.3%	-20.8%	39.3%	Medi-Cal	43.4%	49.4%	-6.0%	-12.1%	47.4%	
18.6%	18.2%	0.4%	2.2%	17.3%	Medicare	18.3%	18.2%	0.1%	0.8%	18.4%	
42.3%	32.4%	9.9%	30.5%	43.4%	Other	38.3%	32.4%	5.9%	18.1%	34.2%	
100.0%	100.0%	0.0%	n/a	100.0%	Total	100.0%	100.0%	0.0%	0.0%	100.0%	
					<u>Patient Days</u>						
4,680	5,172	(492)	-9.5%	4,383	Medi-Cal Patient Days (excl. MHRF)	53,591	59,800	(6,209)	-10.4%	62,239	
2,043	1,825	218	11.9%	1,728	Medicare Patient Days (excl. MHRF)	22,996	20,927	2,069	9.9%	21,360	
2,623	1,311	1,312	100.1%	2,643	Other Patient Days (excl. MHRF)	25,681	17,268	8,413	48.7%	20,453	
9,346	8,308	1,038	12.5%	8,754	Total Patient Days(excl. MHRF)	102,268	97,995	4,273	4.4%	104,052	
4,958	6,019	(1,061)	-17.6%	5,115	Medi-Cal Patient Days	59,305	68,953	(9,648)	-14.0%	70,991	
2,043	1,850	193	10.4%	1,937	Medicare Patient Days	22,996	21,194	1,802	8.5%	21,633	
6,680	4,779	1,901	39.8%	6,105	Other Patient Days	65,839	54,747	11,092	20.3%	55,381	
13,681	12,648	1,033	8.2%	13,157	Total Patient Days	148,140	144,894	3,246	2.2%	148,005	
19,371	18,184	1,187	6.5%	19,424	Adjusted Patient Days	208,947	208,313	634	0.3%	213,392	
82.1%	76.0%	6.1%	8.0%	79.0%	% Occupancy (available beds)	82.3%	80.6%	1.7%	2.1%	82.1%	
					<u>KEY OPERATIONAL INDICATORS</u>						
					<u>Labor</u>						
2,361	2,296	(65)	-2.9%	2,331	FTEs - Productive	2,277	2,296	19	0.8%	2,347	
242	313	71	22.7%	288	FTEs - Non-Productive	324	313	(11)	-3.6%	324	
2,603	2,609	6	0.2%	2,619	Total FTEs - SFGH Only	2,601	2,609	8	0.3%	2,671	
334	334	0	n/a	351	UC Non-Academic FTEs	334	334	0	n/a	351	
2,937	2,943	6	0.2%	2,970	Grand Total FTEs Incl. UC	2,935	2,943	8	0.3%	3,022	
4.7	5.0	0.3	6.0%	4.7	FTEs Per AOB (Incl. UC)	4.7	5.0	0.3	6.0%	4.7	
\$ 60,930	\$ 58,574	(\$2,356)	-4.0%	\$56,936	Average Labor Cost per SFGH FTE	\$ 59,356	\$57,952	(\$1,404)	-2.4%	\$ 56,187	
23.9%	22.8%	-1.1%	-4.8%	24.3%	Fringe Benefits as % of Salary	23.9%	22.8%	-1.1%	-4.8%	23.2%	
288	227	61	26.9%	274	Vacancy positions (as of the last PPE)	288	227	61	26.9%	274	
					<u>Revenues</u>						
\$ 1,366	\$ 1,290	\$76	5.9%	\$1,195	Oper. Rev. Per Adjusted Patient Day (incl. MHRF)	\$ 1,313	\$1,262	\$51	4.0%	\$1,201	
\$ 717	\$ 600	\$117	19.5%	\$549	Oper. Rev. (excl. S8855/1255/GME)/APD	\$ 651	\$600	\$51	8.5%	\$554	
\$ 12,721	\$ 10,411	\$2,310	22.2%	\$10,036	Oper. Rev. Per Adjusted Discharge	\$ 12,026	\$10,292	\$1,734	16.8%	\$10,001	
\$ 6,678	\$ 4,843	\$1,835	37.9%	\$4,613	Oper. Rev. (excl. S8855/1255/GME)/Adj. Discharge	\$ 5,966	\$4,891	\$1,075	22.0%	\$4,615	
					<u>Expenses</u>						
\$ 2,030	\$ 2,051	\$21	1.0%	\$1,969	Operating Exp. Per Adjusted Pt. Day	\$ 1,998	\$1,927	(\$71)	-3.7%	\$1,809	
\$ 1,608	\$ 1,601	(\$7)	-0.4%	\$1,547	Operating Exp.(excl. IGT)/Adj. Pt. Day	\$ 1,567	\$1,495	(\$72)	-4.8%	\$1,386	
\$ 18,909	\$ 16,553	(\$2,356)	-14.2%	\$16,539	Operating Exp. Per Adj. Discharge	\$ 18,302	\$15,715	(\$2,587)	-16.5%	\$15,067	
\$ 14,974	\$ 12,920	(\$2,054)	-15.9%	\$12,994	Operating Exp.(excl. IGT)/Adj. Discharge	\$ 14,355	\$12,191	(\$2,164)	-17.8%	\$11,546	
31.0%	35.5%	4.5%	12.7%	31.0%	Supply Expense as % of Net Pt. Revenue	35.1%	33.8%	-1.3%	-3.8%	35.8%	
84	120	36	30.0%	130	Days Revenue in Accounts Receivable	84	120	36	30.0%	130	

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Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO

Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Arthur R. Greenberg
Interim Health Commission Secretary

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Web Site: <http://www.dph.sf.ca.us>

AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, July 24, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

07-19-01A09:01 RL

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Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: CONSIDERATION OF APPROVING THE MINUTES FOR JUNE 12, 2001.
**Minutes of June 12, 2001*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
**Report*

- 5) **FOR DISCUSSION:** **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Gregg Sass, CHN Chief Financial Officer)
**Report*
- 6) **FOR DISCUSSION:** **PRESENTATION OF THE S.F. TRAUMA CARE PLAN**
(John Brown, M.D., Director EMS Section)
**Plan*
- 7) **GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL****
- 8) **CLOSED SESSION**
- A) Public Comments on All Matters Pertaining to the Closed Session**
- B) Vote on Whether to Hold a Closed Session (San Francisco Administrative Code Section 67.11(a).)
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **TO APPROVE CLOSED SESSION MINUTES OF JUNE 12, 2001**

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE, AND CREDENTIALING MATTERS**

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

- D) Reconvene in Open Session
1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.14(b)(2).)
 2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.14(a).)
- 9) **ADJOURNMENT**

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

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Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine

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MINUTES

JOINT CONFERENCE COMMITTEE MEETING FOR SAN FRANCISCO GENERAL HOSPITAL

Tuesday, July 24, 2001

3:45 p.m.

1001 Potrero Avenue, Room #2A6
San Francisco, CA 941102

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1) CALL TO ORDER

The regular meeting of San Francisco General Hospital was called to order at 3:45 p.m. by Commissioner Lee Ann Monfredini with Commissioner John I. Umekubo, M.D. in attendance.

Present: Commissioner Lee Ann Monfredini
Commissioner John I. Umekubo, M.D.
Commissioner Arthur M. Jackson

Staff: Sue Currin, Cathryn Thurow, Mitchell Katz, M.D., Robert MacKersie, M.D.,
Ana Marino Ghosh, Mozettia Henley, J. Renee Navarro, M.D., Gene
O'Connell, Gregg Sass, Hiroshi Tokubo, and Chris Wachsmuth, Connie
Young and Monique Zmuda

2) APPROVAL OF MINUTES OF THE JCC-SFGH MEETING OF JUNE, 2001

Action Taken: The Committee adopted the minutes of June 12, 2001. The Committee recommended that the minutes and agenda be changed to reflect that J. Renee Navarro, M.D. is the current Chief of Staff.

3) HOSPITAL HEALTHCARE UPDATE
(Gene O'Connell, Executive Administrator)

Departure of Gayling Gee

Gayling Gee, Hospital Associate Administrator for Specialty and Diagnostic Services, will resigning at the end of the month to accept a position at Laguna Honda Hospital as a Hospital Associate Administrator for Nursing. Gayling has dedicated the last 22 years of her life providing impeccable quality services to the patients of San Francisco General Hospital Medical Center. In her career here at SFGH, she has contributed significantly to various programs and services, including but not limited to the Positive Health Program (Ward 86), Oncology, Clinical Laboratories, Perioperative, Specialty Outpatient Clinics, as well as the most newly developed program, Integrated Soft Tissue Infection Service (ISIS).

In planning for Gayling's departure, I've already initiated discussions with the Hospital Associate Administrators and various Chiefs of Services in determining how to provide administrative support for Gayling's areas in the interim until a new administrator can be hired.

San Francisco General Hospital Medical Center will miss Gayling dearly and wish her well in her new position at Laguna Honda Hospital. A reception will be held for her at San Francisco General Hospital Medical Center on July 27th from 2-3:30 p.m. to thank her for all her years of dedication

Avon Grant – Women's Imaging Center

In March 2000, the Avon Products Foundation made a gift of \$2.2 million to the UCSF Comprehensive Cancer Center to support research into the possible causes of breast cancer, and to improve care for medically underserved women. A portion of this initial gift supported improvements at SFGH. In April of 2001, Avon invited a team of UCSF faculty located at both Mt. Zion and SFGH to submit a second request. In collaboration with UCSF representatives and SFGH leaders, the SFGH Foundation is actively pursuing a grant from the Avon Products Foundation that would fund \$4-6 million for programs focused on breast care here at San Francisco General Hospital Medical Center with a tie-in to \$4 million for research and a Mammovan. A substantial portion of the Avon request will go toward improving equipment and facilities. Also at SFGH, funding will give patients access to clinical trials, improve patient education about treatment options, and educate providers throughout the Community Health Network about breast care.

The SFGH portion of the request to Avon will fund:

- Upgrade to digital mammography and replace existing outdated machines
- A facility to house mammography, ultrasound, and bone densitometry
- A staffed patient education resource room
- Continuing education programs for providers

The population served at SFGH currently is twice at risk of dying than their more affluent peers. Early detection is a crucial factor in the mortality and morbidity rates for breast cancer. At present, early detection rates are only half what they are for the Bay Area as a whole. Since 1995, while there has been a steady national decrease in morbidity and mortality from breast cancer, there has been no corresponding change in outcome for the women at SFGH. The number of asymptomatic breast cancers picked up by screening mammography at SFGH is half the national average. SFGH is at capacity offering 4800 mammograms a year, working seven days a week. Currently patients face a 102-day wait for routine screening. Once diagnosed with breast cancer, language and literacy barriers prevent many of our patients from gathering the information they need to make good treatment decisions. Through the Community Health Network, SFGH reaches thousands of low-income and

decisions. Through the Community Health Network, SFGH reaches thousands of low-income and medically underserved women who would benefit from screening. This grant will aid in developing our referral network and serve as an educational resource for them about breast care.

The Avon Products Foundation will be making a site visit this week to San Francisco General Hospital Medical Center to learn more about patient population and the quality services provided. SFGH will continue to update the JCC-SFGH as further information from the Avon Productions Foundation becomes available.

SUMMARY OF FY 2001-2002 SFGHMC BUDGET

Programs (details attached)

\$ 523,000	State funds to fund vacant positions at community health
\$ 208,000	Increased third party revenues for clinical pharmacy management services
\$ 364,000	Increased third party revenues for behavioral focused unit at SFGH
\$ 595,000	Increased third party revenues to fund trauma program enhancements
\$ 747,000	Increased third party revenues to fund traumatic brain injury program
\$ 308,000	Increased third party revenues to expand mammography services
\$ 265,000	Increased third party revenues to fund overnight observation unit
\$ 255,000	Increased third party revenues to fund medical high utilizer initiative
\$1,100,000	MediCal revenues to reinstate costs associated with the continuation of the outpatient pharmacy
<u>\$ 755,000</u>	Increase in third party revenues to fund enhancements to clinical information systems
\$5,120,000	Sub-total

Capital Equipment and Capital Improvement

\$1.46 million approved for Capital Equipment
\$3.87 million approved for Capital Improvement

\$5,330,000 Sub-total

Additional Funding

\$2.6 million add-back to UCSF (distribution to be determined)

\$2,600,000 Sub-total:

Total: \$13,050,000 in new funds

San Francisco General Hospital Medical Center
FY 2001-2002 Budget
New Program Initiatives (All budgeted from October 2001-July 2002)

Program Title	Funded Components
<p align="center">Medical High Utilizer Project</p> <p><i>Goal: To decrease preventable admissions to the medical inpatient wards at SFGH by providing the following services to patients with multiple admissions or patients identified to have a high risk of multiple admissions:</i></p> <ol style="list-style-type: none"> 1) <i>Specialized medical and psychiatric assessment of patients when hospitalized</i> 2) <i>Outpatient case management</i> 3) <i>Ongoing clinic-based consultations with CHN primary care providers</i> 	<p align="center">Labor</p> <p>4.00 FTE of Psychiatric Social Workers 1.00 FTE of Unit Clerk 1.0 FTE of Public Health Nurse</p> <p align="center">UC Contract</p> <p>\$227,905 – 1.3 hospitalist and 0.5 psychiatrist</p>
<p align="center">Filmless Radiology (Year 1)</p> <p><i>Goal: To transition the SFGH Radiology Department's film-based operations to a filmless system in stages over 5 years.</i></p>	<p align="center">Operating Expenses</p> <p><u>Equipment Lease Expense (6 months)-\$72,000*</u> (* difference between lease amount expense of \$372,000 and savings in radiology supplies \$300,000)</p>
Program Title	Funded Components
<p>Expansion of Mammography Services</p> <p><i>Goal: Expand current mammography capacity of 4,800 exams/year to 12,000 exams/year</i></p>	<p align="center">Labor</p> <p>1.0 FTE Supervisory Radiology Tech 2.4 FTE Staff Radiology Tech 1.0 FTE Hospital Eligibility Worker</p> <p align="center">UC Contract</p> <p>\$75,000 for Radiologist</p>
<p>Clinical Pharmacy Management Program</p> <p><i>Goal: To minimize the inappropriate use of antibiotics and antimicrobials to decrease their cost and reduce hospital length of stays.</i></p>	<p align="center">Labor</p> <p>2.5 FTE of Clinical Pharmacist</p>
<p>SFGH ED Overnight Observation Unit</p> <p><i>Goal: To decrease Emergency Department diversion, increase accessibility to emergency services and improve utilization of all treatment areas in the department by transferring adult patients from ED critical care treatment spaces into underutilized treatment rooms in another part of the ED [Zone 4/Westside].</i></p>	<p align="center">Labor</p> <p>1.7 FTE Registered Nurse 1.7 FTE MEA 1.4 FTE Nurse Practitioner/PA</p>

<p>Acute Med/Behavioral Unit</p> <p><i>Goal: To cohort complex med/behavioral inpatients on one unit in order to facilitate physical and behavioral health services</i></p>	<p>Labor</p> <p>6.0 FTE CNA 1.0 FTE CNS 1.0 FTE Medical Social Worker 2.0</p>
<p>Trauma Program Enhancements – Year 2</p> <p><i>Goal: To continue the SFGH Trauma Center as the City's Level I designated center for adults and children by building on the FY 00/01 enhancements that are necessary to maintain compliance with State and American College of Surgeons Level I Trauma Center designation regulations.</i></p>	<p>Labor</p> <p>1.0 FTE NP 0.3 FTE Database Manager</p> <p>UC Contract</p> <p>\$93,000 attending physicians</p> <p>Operating Expenses Independent Contract-Recovery Specialist - \$93,000</p> <p>Trauma Registry Upgrade (1 time) - \$35,000</p> <p>Facilities Maintenance, and Equipment Capital Projects- Trauma Surgeon on-call room remodel \$5,000</p> <p>Capital Projects- Ambulance Dock Resurface \$350,000</p>

Program Title	Funded Components
<p style="text-align: center;">Trauma Brain Injury</p> <p><i>Goal: To improve trauma care for brain injured patients and bring the neuro-trauma program into compliance with new State and American College of Surgeons Level I Trauma Center requirements.</i></p>	<p style="text-align: center;">Labor</p> <p>1.7 FTE NP 1.0 FTE CNS 3.3 FTE Staff Radiology Tech 2.0 FTE Registered Nurse 0.5 FTE Speech Therapist</p> <p style="text-align: center;">UC Contract</p> <p>\$112,500 attending physicians</p> <p style="text-align: center;">Operating Expenses</p> <p>\$30,000 Neuro-Psychologist Consultation \$37,500 Sitter Registry \$1,500 Brain Train Cognitive Retraining software</p> <p>Facilities Maintenance, and Equipment \$6,000 Vail System Restraint Bed (1 time) \$16,500 Wander Sensor System</p>
<p style="text-align: center;">Expansion of Home Health Services to Children</p> <p><i>Goal: To expand home health services to children from birth up to age 21 years referred from the California Children's Service (CCS) program</i></p>	<p style="text-align: center;">Labor</p> <p>0.6 FTE Registered Nurse 1.0 FTE Physical Therapist 1.0 FTE Health Care Billing Clerk</p> <p style="text-align: center;">Operating Expenses</p> <p>\$3,750 Training & Staff Mileage Expense \$3,750 Computer, Software, License, Therapy Equipment</p>

4) **PATIENT CARE REPORT**
(Sue Currin, RN, Chief Nursing Officer)

Ms. Currin presented the Patient Care Report, see Attachment A.

5) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Gregg Sass, CHN Chief Financial Officer)

Mr. Sass submitted the Statement of Revenue and Expenses ending June 30, 2001, and the Summary Statistical Information (June 30, 2001), see Attachment B.

- 6) PRESENTATION OF THE S.F. TRAUMA CARE PLAN
(John Brown, M.D., Director EMS Section)

Dr. Brown presented the San Francisco Trauma Care Plan, see Attachment C.

- 7) GENERAL PUBLIC COMMENTS ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL

None.

- 8) PUBLIC COMMENTS ON ALL MATTERS PERTAINING TO THE CLOSED SESSION

None.

The Committee went into closed session at 5:20 p.m.

Individuals present in the closed session were the same as in the open session.

- 9) CLOSED SESSION PURSUANT TO EVIDENCE CODE SECTIONS 1157(a) AND (b); 1157.7, HEALTH AND SAFETY CODE SECTION 14641; AND CALIFORNIA CONSTITUTION, ARTICLE I, SECTION 1

Action Taken: The Committee approved the Closed Session minutes of June 12, 2001

**CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE,
QUALITY ASSURANCE AND CREDENTIALING MATTERS**

The Committee came out of Closed Session at 5:49 p.m.

- 10) RECONVENE IN OPEN SESSION

Action Taken: The Committee voted not to disclose any discussions held in Closed Session, (San Francisco Administrative Code Section 67.12(a).

Chair Lee Ann Monfredini acknowledged that the SFGH July 2001 Physician Credentials were approved at the July 10, 2001 Health Commission meeting.

- 11) AJOURNMENT

The meeting was adjourned at 5:55 p.m.


Michele M. Olson*

Health Commission Secretary

Attachments (3)

*Minutes were taken by Connie Young

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 7/24/01

Sue Currin, RN, MS, Chief Nursing Officer

1. Committee on Interdisciplinary Practice (CIDP)

Renee Nayarro, MD- Chief of Staff, appointed Sue Currin to co-chair the CIDP with Martha Neighbor, MD-ED. The CIDP is in the process of developing a policy to clarify the role of the committee in reviewing and forwarding recommendations on standardized procedures (SPs) and Allied Health Professionals' credential files to the Credentials Committee. The CIDP will also be rescheduling meeting times to coincide with those of the Credentials and Medical Executive Committees. Plans are currently under way to place approved SPs on the Intranet to facilitate staff access to protocols in the patient care areas.

2. Recruitment/Retention Activities

AREA	TRAINING PROGRAM			ORIENTATION PROGRAM		
	RN	LVN/LPT	TARGET COMPLETION DATE	RN	LVN/LPT	TARGET COMPLETION DATE
Acute Psychiatry	5	2	RN-9/7/01 LVN/LPT-8/31/01	5	1	RN-8/13/01 LVN/LPT-8/13/01
Emergency Department	6		RN-9/15/01	4		RN-9/15/01 RN-10/6/01 (Start date 8/27/01)
Mental Health Rehab	2	1	RN-8/31/01 LPT-8/31/01		1	LPT-8/1/01
Operating Room	3		RN-11/2/01			
Med-Surg				2	4	LVN-8/24/01
Critical Care	8		RN -5 complete 9/14/01 -2 complete 11/30/01 -2 complete 12/21/01			
TOTAL	24	3		13	6	

In addition to the 37 RNs and 9 LVNs/LPTs in training and orientation programs listed above, the medical-surgical areas have hired 10 RNs in the UCSF/SFSU graduate program who have just received their license. The RNs will be working as per diem staff over the next 12 months as they complete their studies.

•Vacancy Rates- 7/01

RN	LVN/LPT
7% (~38 FTE)	13% (~28FTE)

The RN vacancy rate is below 5% in critical care, emergency department, med-surg, perinatal services, and mental health rehab. The operating room and acute psychiatry have the highest vacancy rates at 14% each.

The LVN/LPT vacancy rate continues to be over 10%, with the acute psychiatry and mental health rehab rates at 19% and 9% respectively. The shortage of trained LPTs continues to be low throughout the state. A training program for LVNs in acute psychiatry was designed to fill the gaps created by the LPT vacancies. Recruitment efforts continue to focus on LVNs who have mental health experience.

3. MHRF Nursing Director

Mark Crider, RN, MS-Nursing Director-MHRF, has resigned to accept a teaching position at Dominican College. Mark will be coordinating the LVN/RN to BSN program at the college. We are looking forward to assisting Mark with student placements in our med-surg and mental health areas. Recruitment efforts are underway to fill the vacancy left by Mark's departure.

4. JCAHO Preparation

The nursing areas are preparing for the JCAHO mock survey scheduled to begin 9/10/01. An assessment of our current compliance to the 2001 JCAHO standards is underway and the nursing staff is preparing for unit interviews. Nursing is working with support services to correct deficiencies identified during ongoing Environment of Care audits.

5. Restraints

Audits have shown a decrease in the use of physical restraints since the revised policy and procedure was implemented in the first quarter of this year. The decrease is due in part to the cohorting of patients with medical-behavioral care needs on unit 5C. The number of beds designated for this patient population will be expanded as CNA positions are transferred from the emergency department to unit 5C over the summer.

6. Diversion Summary Report

See attached.

San Francisco General Hospital

Diversion Report

JUNE 2001

Executive Summary

The Emergency Department [ED] recorded 40 episodes of diversion for 173 hours representing a rate of 24 % for June 2001. This is a 1.0 % increase in diversion since May 2001.

The 40 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from previous month
Total diversion	36	164	23%	2% increase
Trauma over-ride	4	9	1%	1% decrease

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 198 patients were awaiting admission to in-patient beds [ICU-27 4B/StepDown-79 MedSurg-92]. In June of 2000, the ED was on diversion 36% of the month. Trauma Override was invoked 3 % of the month in June 2000.

Total diversion was recorded for 36 episodes, a total of 164 hours or a 23 % rate for June 2001.

Trauma override was recorded for 4 episodes, a total of 9 hours or a 1 % rate for June 2001. This is a 1% decrease in trauma override from May 2001. While on Trauma override the ED held 26 patients awaiting inpatient beds.

Definitions:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSA definitions:

Total diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Pat Nagle R.N.
Base Hospital Coordinator

San Francisco General Hospital
Emergency Department
2001
Total Diversion Summary

In June, the Emergency Department recorded 40 episodes of Total Diversion for 173 hours and 15 min, a percentage of 24 % for the month.

Date	Length	Summary of Event
06/01/01	1735-1825	33 patients in the ED Admits: 1-4B, 4-Floor, 1-direct admit ED waiting room: 5 urgent patients
06/01/01	2110-0420	32 patients in the ED Admits: 5-Floor ED waiting room: 9 urgent patients
06/02/01	1415-1805	31 patients in the ED Admits: 1-Floor ED waiting room: 4 urgent patients
06/02/01	2230-0240	28 patients in the ED Admits: 4-4B ED waiting room: 4 urgent patients
06/03/01	1356-1605	25 patients in the ED Admits: 1-ICU, 1-4B ED waiting room: Nil
06/04/01	1430-0245	43 patients in the ED Admits: 3-4B ED waiting room: 6 urgent patients
06/05/01	1528-1730	Nil patients in the ED Admits: 4-4B Direct Admit: 4 Ed waiting room: Nil
06/05/01	1940-0030	Nil patients in the ED Admits: 4-4B, 6-Floor ED waiting room: Nil
06/06/01	1855-1930	24 patients in the ED Admits: Nil Ed waiting room: Nil
06/07/01	2320-0106	36 patients in the ED Admits: 2-ICU, 3-4B, 2-2 nd Floor ED waiting room: 10 urgent patients
06/08/01	1453-1845	50 patients in the ED Admits: 3-4B, 4-Floor ED waiting room: 10 urgent patients
06/09/01	1530-1805	33 patients in the ED Admits: 3-4B, 2-Floor ED waiting room: 6 urgent patients
06/11/01	1400-1840	45 patients in the ED Admits: Nil ED waiting room: 3 urgent patients
06/12/01	0750-0900	12 patients in the ED Admits: 1-ICU, 1-4B, 1-Floor ED waiting room: Nil
06/12/01	2130-0250	32 patients in the ED Admits: 1-4B, 30-Floor Direct Admit: 1 ED waiting room: 6 urgent patients
06/13/01	1910-0430	27 patients in the ED Admits: 2-ICU

		ED waiting room: 6 urgent patients
06/14/01	1200-1730	10 patients in the ED Admits: 3-4B, 1-Floor ED waiting room: Nil
06/14/01	2100-0500	34 patients in the ED Admits: 1-ICU, 1-4B, 3-Floor ED waiting room: 6 urgent patients
06/15/01	1620-1715	32 patients in the ED Admits: 1-4B, 1-Floor ED waiting room: Nil
06/16/01	1827-2050	33 patients in the ED Admits: 1-ICU, 4-4B, 2-Floor ED waiting room: Nil
06/17/01	1555-1910	32 patients in the ED Admits: 1-4B, 2-Floor ED waiting room: 6 urgent patients
06/18/01	1520-2230	29 patients in the ED Admits: 1-ICU, 5-4B Direct Admit: 2 ED waiting room: 4 urgent patients
06/19/01	2020-0200	32 patients in the ED Admits: 1-ICU, 4-Floor ED waiting room: Nil
06/20/01	1655-2220	31 patients in the ED Admits: 1-4B, 3-Floor ED waiting room: 8 urgent patients
06/22/01	1440-1810	44 patients in the ED Admits: 1-PED, 2-Floor ED waiting room: Nil
06/23/01	0050-0620	39 patients in the ED Admits: 3-4B, 2-Floor ED waiting room: 8 urgent patients
06/24/01	2035-2220	27 patients in the ED Admits: 4-ICU, 2-4B, 3-Floor ED waiting room: 4 urgent patients
06/25/01	0445-0715	28 patients in the ED Admits: 1-ICU, 1-4B, 4-Floor ED waiting room: 4 urgent patients
06/25/01	1315-1720	38 patients in the ED Admits: 4-ICU, 1-4B, 2-Floor ED waiting room: 15 urgent patients
06/25/01	1950-0150	29 patients in the ED Admits: 3-Floor Direct Admits: 2 ED waiting room: 12 urgent patients
06/26/01	1345-1430	24 patients in the ED Admits: 4-4B ED waiting room: Nil
06/26/01	1630-2220	35 patients in the ED Admits: 1-ICU, 4-4B, 3-Floor ED waiting room: 7 urgent patients
06/26/01	2305-0530	31 patients in the ED Admits: 1-ICU, 2-4B ED waiting room: 15 urgent patients
06/27/01	1228-1805	28 patients in the ED Admits: Nil ED waiting room: Nil
06/28/01	1035-1320	36 patients in the ED Admits: 2-4B, 6-Floor ED waiting room: Nil
06/28/01	2135-2240	31 patients in the ED Admits: 1-ICU, 4-4B, 5-Floor ED waiting room: 7 urgent patients

06/28/01	- 2332-0450	36 patients in the ED Admits: 1-4B, 3-Floor ED waiting room: 12 patients
06/29/01	1945-2130	32 patients in the ED Admits: 2-4B, 3-Floor ED waiting room: Nil
06/30/01	1243-1700	27 patients in the ED Admits: Nil ED waiting room: Nil
06/30/01	2245-2345	25 patients in the ED Admits: 3-ICU, 2-4B ED waiting room: Nil

San Francisco General Hospital
Emergency Department
2001
Trauma Override Summary

The Emergency Department recorded 4 episodes of Trauma Override for 9 hours and 03 min, a percentage of 1.2 % for the month of June.

Date	Length	Summary of Event
6/14/01	2317-0317	911-1, 912-3, 26 patients in the ED
6/25/01	1438-1538	911-2, 912-1, 38 patients in the ED
6/25/01	2250-0120	911-Nil, 912-2 29 patients in the ED
6/26/01	2047-2220	911-7, 912-3 31 patients in the ED

San Francisco General Hospital
Statement of Revenue and Expenses
Month ending June 30, 2001

Overview:

Monthly Results:

Net Income, Page 1, Line 61, Column 3

Net income for the month of June exceeds Budget by \$5,903,000. Of this amount, \$6,822,000 is due to favorable adjustments to SB855 Revenues, (line 24), and Operating Transfers out, (line 43), to reflect the final year-end net transfer for Disproportionate Share payments from the State. Notice of the final allocation amount and actual payment of the final installment occurred in June.

	<u>Projection</u>	<u>Budget</u>	<u>Difference</u>
Line 24, SB855 Revenue	\$(12,780,000)	\$10,626,000	\$(23,406,000)
Line 43, Operating Transfer Out	\$(22,043,000)	\$ 8,185,000	\$ 30,228,000
Difference	\$ 9,263,000	\$ 2,441,000	\$ 6,822,000

Other, largely offsetting, year-end adjustments were made to adjust year-end accruals to Contractual Services, (line 37), Pharmaceuticals, (line 39), Revenue from other City Departments, (line 27) Prior Year Settlement, (line 28), Capitation / Managed Care Settlement, (line 21) and the Provisions for Medicare and Medi-Cal Adjustments (line 12 & 13).

Gross Patient Revenue, Page 1, Line 8, Column 3

Gross patient revenue exceeded budget \$7,415,000 or 21.8%. This is consistent with the variance in average daily census of 9.5% (page 2, line 7).

Annual Results:

Net Income, Page 1, Line 61, column 6

The \$5,903,000 favorable variance for the month reverses the projected loss reported in May of \$(2,722,000) resulting in a projected net income of \$3,127,000. As discussed above, the primary source of new income was the final year-end net transfer for Disproportionate Share payments from the State.

	<u>Projection</u>	<u>Budget</u>	<u>Difference</u>
Line 24, SB855 Revenue	\$104,112,000	\$127,518,000	\$(23,406,000)
Line 43, Operating Transfer Out	\$ 67,996,000	\$ 98,225,000	\$ 30,229,000
Difference	\$ 36,116,000	\$ 29,293,000	\$ 6,823,000

Personnel Services, Page 1, Line 35, column 6

Projected expenses for the year exceeds budget by \$2,797,000, which largely is a result of additional staffing costs associated with additional inpatient volume.

Mandatory Fringe Benefits, Page 1, line 36, column 6

While Fringe Benefits exceeded budget for the year, total projected expense is consistent with the amount incurred in the prior year.

Contractual Services, Page 1, line 39, column 6

Projected expenses are forecast to be less than budget. The \$4,181,000, 4.1% variance offsets unfavorable variances in other categories of expense.

**San Francisco General Hospital
Statement of Revenue and Expenses
Month ending June 30, 2001**

Statistical indicators:

Patient Days Page 2, Line 25, 30, and 31, Column 6

Patient days, excluding MHRF exceed budget 4.7%. Including MMRF patient days exceed budget 2.5%.

Adjusted Patient Days, which factor in outpatient activity exceed budget by 0.7%.

FTEs per adjusted occupied bed, Page 2, Line 43, column 6

Despite the unfavorable variance in total Personnel Services expense, the number of FTEs per adjusted occupied bed are favorable compared to budget, indicating the efficient use of staffing to manage unbudgeted patient days.

Days Revenue in Accounts Receivable, Page 2, Line 61, column 6

The investment in accounts receivable has declined from the prior year level of 134 days to 84 days. This also represents a positive variance from the budgeted value of 120 days.

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/01
Month Ending: JUN 30, 2001

CURRENT MONTH				
Actual	Budget	Variance	% Var	Prior Year
1,349	1,406	(57)	-4.1%	1,406
1,938	2,021	(83)	-4.1%	2,074
182	169	13	7.7%	181
94	92	2	2.2%	97
24	13	11	84.6%	13
300	274	26	9.5%	291
138	140	(2)	-1.4%	140
438	414	24	5.8%	431
6	7	(1)	-12.9%	9
6.7	5.9	(0.8)	-13.6%	6.2
1,338	1,295	0.043	3.3%	1,295
40.8%	49.4%	-8.6%	-17.4%	48.0%
18.6%	18.2%	0.4%	2.4%	18.0%
40.6%	32.4%	8.2%	25.2%	34.1%
100.0%	100.0%	0.0%	n/a	100.0%
4,711	5,091	(380)	-7.5%	4,949
2,140	1,793	347	19.4%	1,907
2,131	1,336	795	59.5%	1,875
8,982	8,220	762	9.3%	8,731
4,802	5,910	(1,108)	-18.7%	5,594
2,140	1,817	323	17.8%	1,907
6,178	4,693	1,485	31.6%	5,428
13,120	12,420	700	5.6%	12,929
18,849	17,857	992	5.6%	19,069
81.4%	77.1%	4.3%	5.6%	80.3%
2,345	2,296	(49)	-2.2%	2,289
300	313	13	4.1%	341
2,645	2,609	(36)	-1.4%	2,630
0	334	334	100.0%	351
2,645	2,943	298	10.1%	2,981
4.2	4.9	0.7	14.3%	4.7
\$ 59,314	\$ 57,700	(\$1,614)	-2.8%	\$55,593
24.6%	22.8%	-1.8%	-7.9%	33.0%
274	227	47	20.7%	293
\$ (9)	\$ 1,349	(\$1,358)	-100.7%	(\$164)
\$ 566	\$ 647	(\$81)	-12.5%	\$1,074
\$ (88)	\$ 11,920	(\$12,008)	-100.7%	(\$1,504)
\$ 5,504	\$ 5,714	(\$210)	-3.7%	\$9,875
\$ 372	\$ 2,106	\$1,734	82.3%	\$157
\$ 1,542	\$ 1,647	\$105	6.4%	\$1,535
\$ 3,620	\$ 18,604	\$14,984	80.5%	\$1,447
\$ 14,995	\$ 14,554	(\$441)	-3.0%	\$14,114
39.5%	36.3%	-3.2%	-8.8%	32.2%
84	120	36	30.0%	134

KEY VOLUME INDICATORS

Discharges (Incl. MHRF)

Discharges (incl. MHRF)

Adjusted Discharges (incl. MHRF)

Average Daily Census

Acute Med/Surg ADC

Psych ADC

Skilled Nursing ADC

Total ADC excl. MHRF

MHRF ADC

Total Adult ADC

Nursery ADC

Average Length of Stay (excl. MHRF)

Medicare Case Mix Index

Payer Mix (Gross Revenue)

Medi-Cal

Medicare

Other

Total

Patient Days

Medi-Cal Patient Days (excl. MHRF)

Medicare Patient Days (excl. MHRF)

Other Patient Days (excl. MHRF)

Total Patient Days(excl. MHRF)

Medi-Cal Patient Days

Medicare Patient Days

Other Patient Days

Total Patient Days

Adjusted Patient Days

% Occupancy (available beds)

KEY OPERATIONAL INDICATORS

Labor

FTEs - Productive

FTEs - Non-Productive

Total FTEs - SFGH Only

UC Non-Academic FTEs

Grand Total FTEs Incl. UC

FTEs Per AOB (Incl. UC)

Average Labor Cost per SFGH FTE

Fringe Benefits as % of Salary

Vacancy positions (as of the last PPE)

Revenues

Oper. Rev. Per Adjusted Patient Day (incl. MHRF)

Oper. Rev. (excl. S8855/1255/GME)/APD

Oper. Rev. Per Adjusted Discharge

Oper. Rev. (excl. S8855/1255/GME)/Adj. Discharge

Expenses

Operating Exp. Per Adjusted Pt. Day

Operating Exp.(excl. IGTV/Adj. Pt. Day

Operating Exp. Per Adj. Discharge

Operating Exp.(excl. IGTV/Adj. Discharge

Supply Expense as % of Net Pt. Revenue

Days Revenue In Accounts Receivable

YEAR-TO-DATE				
Actual	Budget	Variance	% Var	Prior Year
17,525	19,176	(1,651)	-8.6%	19,176
24,751	27,568	(2,817)	-10.2%	27,689
189	178	11	6.2%	192
92	93	(1)	-1.1%	95
23	20	3	15.0%	21
304	291	13	4.5%	308
137	140	(3)	-2.1%	132
441	431	10	2.3%	440
6	7	(1)	-14.3%	12
6.4	6.1	(0.3)	-4.9%	5.9
1,338	1,295	0.043	3.3%	1,295
43.2%	49.4%	-6.2%	-12.6%	47.4%
18.4%	18.2%	0.2%	0.9%	18.3%
38.5%	32.4%	6.1%	18.7%	34.2%
100.0%	100.0%	0.0%	n/a	100.0%
58,302	64,891	(6,589)	-10.2%	67,188
25,136	22,720	2,416	10.6%	23,267
27,812	18,604	9,208	49.5%	22,328
111,250	106,215	5,035	4.7%	112,783
64,107	74,863	(10,756)	-14.4%	76,585
25,136	23,011	2,125	9.2%	23,540
72,017	59,440	12,577	21.2%	60,809
161,260	157,314	3,946	2.5%	160,934
227,796	226,170	1,626	0.7%	232,461
82.1%	80.3%	1.8%	2.2%	81.9%
2,283	2,296	13	0.6%	2,342
322	313	(9)	-3.0%	326
2,605	2,609	4	0.2%	2,668
0	334	334	100.0%	351
2,605	2,943	338	11.5%	3,019
4.7	4.9	0.2	4.9%	4.7
\$ 59,353	\$57,931	(\$1,421)	-2.5%	\$ 56,137
23.9%	22.8%	-1.1%	-4.8%	24.1%
274	227	47	20.7%	293
\$ 1,204	\$1,309	(\$105)	-8.0%	\$1,089
\$ -	\$644	(\$644)	-100.0%	\$597
\$ 11,077	\$10,742	\$335	3.1%	\$9,139
\$ -	\$5,282	(\$5,282)	-100.0%	\$5,009
\$ 1,864	\$1,982	\$118	6.0%	\$1,673
\$ 1,565	\$1,547	(\$18)	-1.2%	\$1,398
\$ 17,153	\$16,258	(\$895)	-5.5%	\$14,047
\$ 14,405	\$12,695	(\$1,710)	-13.5%	\$11,739
35.4%	34.0%	-1.4%	-4.1%	35.5%
84	120	36	30.0%	134

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/01

Month Ending: JUN 30, 2001

(In Thousands of Dollars)

MONTHLY						ANNUAL					
Fav/(Unfav)						Fav/(Unfav)					
Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual	
GROSS PATIENT REVENUE:						GROSS PATIENT REVENUE:					
12,559	12,805	(246)	-1.9%	12,255	Inpatient Medi-Cal Revenue	153,288	162,187	(8,899)	-5.5%	150,619	
4,338	4,001	337	8.4%	4,212	Outpatient Medi-Cal Revenue	50,578	50,683	(105)	-0.2%	47,210	
5,515	4,416	1,099	24.9%	4,316	Inpatient Medicare Revenue	63,264	55,938	7,326	13.1%	54,766	
2,198	1,763	435	24.7%	1,852	Outpatient Medicare Revenue	23,428	22,334	1,094	4.9%	21,725	
10,748	6,422	4,326	67.4%	6,708	Inpatient Other Revenue	117,606	81,338	36,268	44.6%	83,296	
6,048	4,584	1,464	31.9%	4,991	Outpatient Other Revenue	63,963	58,057	5,906	10.2%	59,349	
<u>41,406</u>	<u>33,991</u>	<u>7,415</u>	<u>21.8%</u>	<u>34,334</u>	TOTAL PATIENT SERVICE REVENUE	<u>472,127</u>	<u>430,537</u>	<u>41,590</u>	<u>9.7%</u>	<u>416,965</u>	
REVENUE DEDUCTIONS:						REVENUE DEDUCTIONS:					
7,198	5,526	(1,672)	-30.3%	5,892	Charity Care	80,137	70,000	(10,137)	-14.5%	58,268	
19,670	11,841	(7,829)	-66.1%	12,229	Provision for Medi-Cal Adjustments	162,599	149,972	(12,627)	-8.4%	149,060	
4,272	2,211	(2,061)	-93.2%	434	Provision for Medicare Adjustments	43,499	28,000	(15,499)	-55.4%	27,475	
79	3,826	3,747	97.9%	4,986	Provision for Other Adjustments	54,723	48,463	(6,260)	-12.9%	53,287	
1,605	1,917	312	16.3%	2,967	Provision for Bad Debt	19,022	23,000	3,978	17.3%	23,598	
<u>32,824</u>	<u>25,321</u>	<u>(7,503)</u>	<u>-29.6%</u>	<u>26,508</u>	TOTAL REVENUE DEDUCTIONS	<u>359,980</u>	<u>319,435</u>	<u>(40,545)</u>	<u>-12.7%</u>	<u>311,688</u>	
<u>8,582</u>	<u>8,670</u>	<u>(88)</u>	<u>-1.0%</u>	<u>7,826</u>	NET PATIENT SERVICE REVENUE	<u>112,147</u>	<u>111,102</u>	<u>1,045</u>	<u>0.9%</u>	<u>105,277</u>	
OTHER OPERATING REVENUE:						OTHER OPERATING REVENUE:					
1,783	663	1,120	168.9%	1,256	Capitation/Managed Care Settlement	9,537	7,959	1,578	19.8%	6,248	
80	388	(308)	-79.4%	1,967	Short Doyle	4,346	4,654	(308)	-6.6%	5,359	
704	704	0	n/a	704	MHRF Funding	8,453	8,453	0	n/a	8,453	
(12,780)	10,626	(23,406)	-220.3%	(25,518)	SB855	104,112	127,518	(23,406)	-18.4%	91,373	
1,833	1,808	25	1.4%	1,808	SB1255	22,000	21,700	300	1.4%	21,700	
108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300	
(170)	830	(1,000)	-120.5%	9,654	Revenue from Other City Departments	8,960	9,960	(1,000)	-10.0%	9,654	
(645)	0	(645)	n/a	(178)	Prior Year Settlement	(679)	0	(679)	n/a	(667)	
333	292	41	14.0%	(749)	MAA & Other Net Patient Revenue	4,000	4,555	(555)	-12.2%	4,363	
<u>(8,754)</u>	<u>15,419</u>	<u>(24,173)</u>	<u>-156.8%</u>	<u>(10,948)</u>	TOTAL OTHER OPERATING REVENUE	<u>162,029</u>	<u>186,099</u>	<u>(24,070)</u>	<u>-12.9%</u>	<u>147,783</u>	
<u>(172)</u>	<u>24,089</u>	<u>(24,261)</u>	<u>-100.7%</u>	<u>(3,122)</u>	TOTAL OPERATING REVENUE	<u>274,176</u>	<u>297,201</u>	<u>(23,025)</u>	<u>-7.7%</u>	<u>253,060</u>	
OPERATING EXPENSES:						OPERATING EXPENSES:					
13,659	12,799	(860)	-6.7%	12,340	Personnel Services	154,171	151,374	(2,797)	-1.8%	148,920	
3,357	2,920	(437)	-15.0%	4,068	Mandatory Fringe Benefits	36,891	34,490	(2,401)	-7.0%	35,819	
6,212	8,410	2,198	26.1%	3,199	Contractual Services	97,431	101,612	4,181	4.1%	85,717	
3,369	2,148	(1,221)	-56.8%	1,216	Materials and Supplies (excl. Pharm.)	26,996	26,275	(721)	-2.7%	22,433	
17	1,000	983	98.3%	1,307	Pharmaceuticals	12,726	12,000	(726)	-6.1%	14,956	
511	382	(129)	-33.8%	(942)	Facilities Maint. & Capital Outlay	6,133	6,133	0	n/a	1,385	
1,325	1,245	(80)	-6.4%	(350)	Services of Other Departments	15,993	14,987	(1,006)	-6.7%	13,251	
(6)	(106)	(100)	-94.3%	9,473	Expenditure Recovery	(1,172)	(1,272)	(100)	-7.9%	(927)	
(22,043)	8,185	30,228	369.3%	(26,271)	Operating Transfer Out	67,996	98,225	30,229	30.8%	63,914	
187	187	0	n/a	133	Intrafund Transfer	2,248	2,248	0	n/a	1,590	
0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0	
428	428	0	n/a	(1,171)	Projects	5,131	5,131	0	n/a	1,890	
<u>7,016</u>	<u>37,598</u>	<u>30,582</u>	<u>81.3%</u>	<u>3,002</u>	TOTAL OPERATING EXPENSES	<u>424,544</u>	<u>451,203</u>	<u>26,659</u>	<u>5.9%</u>	<u>388,948</u>	
<u>(7,188)</u>	<u>(13,509)</u>	<u>6,321</u>	<u>46.8%</u>	<u>(6,124)</u>	OPERATING INCOME/(LOSS)	<u>(150,368)</u>	<u>(154,002)</u>	<u>3,634</u>	<u>2.4%</u>	<u>(135,888)</u>	
NON-OPERATING REVENUE:						NON-OPERATING REVENUE:					
6,053	5,925	128	2.2%	24,193	General Fund	72,637	72,637	0	n/a	65,350	
5,093	5,093	0	n/a	5,738	Realignment	61,113	61,113	0	n/a	58,733	
313	312	1	0.3%	508	Prop 99	3,751	3,751	0	n/a	6,101	
227	205	22	10.7%	99	Transfer In and Project-Related	2,723	2,723	0	n/a	2,265	
876	836	40	4.8%	(8,295)	Carryforward	10,074	10,074	0	n/a	0	
51	87	(36)	-41.4%	66	Cafeteria	758	1,038	(280)	-27.0%	877	
(359)	214	(573)	-267.8%	278	Miscellaneous	2,439	2,666	(227)	-8.5%	2,905	
<u>12,254</u>	<u>12,672</u>	<u>(418)</u>	<u>-3.3%</u>	<u>22,587</u>	TOTAL NON-OPERATING REVENUE	<u>153,495</u>	<u>154,002</u>	<u>(507)</u>	<u>-0.3%</u>	<u>136,231</u>	
<u>5,066</u>	<u>(837)</u>	<u>5,903</u>	<u>705.3%</u>	<u>16,463</u>	NET INCOME/(LOSS)	<u>3,127</u>	<u>0</u>	<u>3,127</u>	<u>n/a</u>	<u>343</u>	

Attachment B



**SAN FRANCISCO TRAUMA CARE SYSTEM PLAN
PRESENTATION TO SAN FRANCISCO GENERAL HOSPITAL
JOINT CONFERENCE COMMITTEE of the
SAN FRANCISCO HEALTH COMMISSION**

JOHN BROWN, M.D., EMS SECTION MEDICAL DIRECTOR

7/24/01

1. Why are we developing a new Trauma Plan?

- To address current trauma system vulnerabilities, including medical transport demands and constraints, provider staffing resources limitations, trauma system oversight and data availability
- To comply with state regulatory changes—Title 22, Division 9, Chapter 7, Section 100253 (Trauma Care Systems Regulations) passed in August, 1999 mandates an updated trauma plan be filed within 2 years in a required format
- To improve EMS care of trauma patients by evaluating the effectiveness of our interventions better—current data system wide is inadequate
- To preserve the Trauma Center (meet American College of Surgeons guidelines)

2. What are the objectives of the Trauma Plan 2001?

- Evaluate need, costs, risks, benefits, feasibility and impact of improved air medical access for San Francisco trauma system
- Preserve the patient volume and severity of injury needed to maintain trauma center designation in the system
- Improve the management and quality assurance structures and processes for the trauma system
- Improve pediatric trauma care

3. What are the changes to the Trauma Plan 1990?

- Support of trauma system elements, e.g. the improvement of medical air access, pediatric trauma transfer and regional cooperation
- Improved trauma system management with Trauma Audit Committees
- Improved data collection, linkage and continuous quality improvement processes
- Participation in the direction of the trauma system from prehospital, trauma center, community hospitals, rehabilitation and prevention elements

4. Where are we going with a new Trauma System?

- The EMS Section is attempting a true paradigm shift, to move the system from:
 - Reactive to Proactive—foresee emerging problems and liability exposures prior to their becoming a crisis to manage
 - Exclusive to Inclusive—move from a trauma center, in-patient-focused system to a spectrum of prevention, field triage, effective treatment at EMS and hospital, and patient rehabilitation
 - Static, anecdotally driven to dynamic, data-driven decision making to improve efficiency and patient outcome.

The San Francisco Trauma Care System Plan	
EMS Section	Department of Public Health

Presentation Outline
<ul style="list-style-type: none"> • What is the Trauma Care System Plan? <ul style="list-style-type: none"> – Background—EMS and Trauma Systems – Trauma Plan Goals • What's New in the Trauma Plan? <ul style="list-style-type: none"> – Trauma System Environment <ul style="list-style-type: none"> • Vulnerabilities in the Trauma System • New Title 22 Regulations • What do the Changes Mean to You?

Presentation Outline, continued
<ul style="list-style-type: none"> • Trauma Plan Approval Process • Current Status • Comments/Discussion

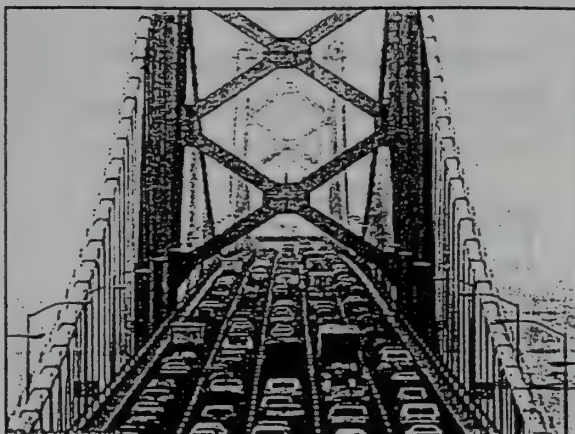
Background--What is the Trauma Care System Plan?
<ul style="list-style-type: none"> • EMS System <ul style="list-style-type: none"> – State law requires EMS Agency to plan, regulate and monitor EMS System (hospital, fire, ambulance, etc.) inc. trauma • Trauma Care System <ul style="list-style-type: none"> – Integration of EMS and trauma care resources to reduce preventable injury deaths and improve patient outcomes

Trauma Care System Plan Goals
<ul style="list-style-type: none"> • Decrease Injury Morbidity and Mortality in San Francisco <ul style="list-style-type: none"> – Ensure rapid access to appropriate levels of care – Ensure seamless pediatric trauma care – Improve long-term trauma outcomes – Improve injury surveillance, prevention, public education

Trauma Care System Plan Goals (cont'd.)
<ul style="list-style-type: none"> • Evaluate Trauma System Quality & Cost-Effectiveness <ul style="list-style-type: none"> – Monitor trauma system process, structures outcomes and costs with continuous quality improvement process

The Trauma System Environment

- SF: 47 sq. miles
- Isolated: bordered by water on 3 sides
- High pop. density → congestion
 - SF: 17,000/sq. mi. in yr. 2000
 - 15,000/sq.mi. in 1990
 - Ranks 2nd after New York City in density
 - Second worst traffic congestion in U.S.
 - Texas Transportation Institute 2001 Urban Mobility Study

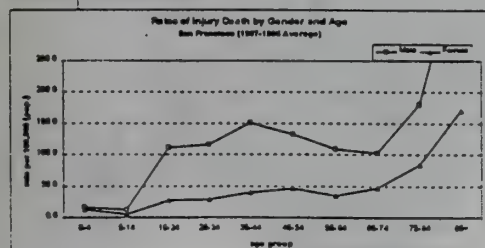


The Trauma System Environment (cont'd.)

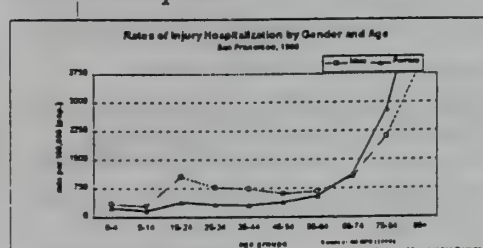
- Earthquake prone
- Vulnerable to Multiple Casualty Incidents
- Transportation to trauma care limited to congested ground/bridge routes



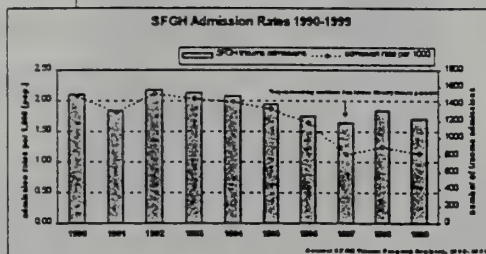
Trauma System Environment: Injury Death Rates in San Francisco



Trauma System Environment: Rates of Injury Hospitalization-- all SF Hospitals

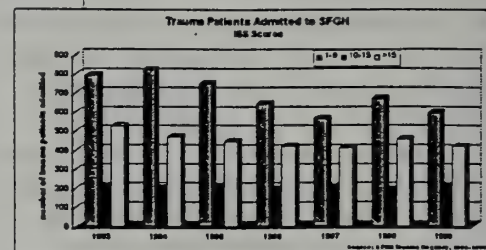


Trauma System Environment: SFGH Trauma Admission Rates



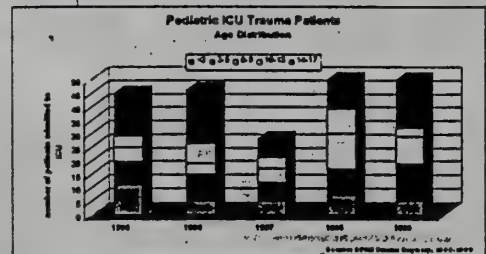
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Trauma System Environment: Injury Severity



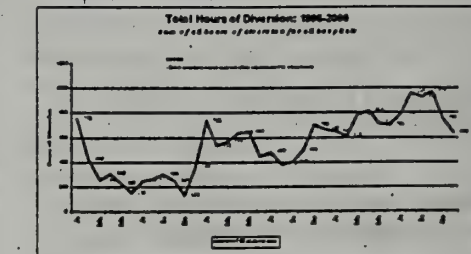
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Trauma System Environment: SFGH Pediatric ICU Admissions



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Trauma System Environment: Diversions



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The Trauma System Environment (cont'd.)

- Single trauma receiving facility in SF
- Low volume pediatric trauma
- Reliance on UCSF faculty, house staff
- Decreasing number of acute care hospitals & hospital beds → diversion
- Potential trauma-related RN, physician shortage

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The Existing Trauma System

- Innovations in Trauma Care Since the Early 1900's
 - County-wide DPH network of first-aid stations
 - DPH Paddy Wagons transport to hospitals
 - Trauma research since 1960's, led to institution of Trauma Center at SFGH

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The Existing Trauma System (cont'd.)

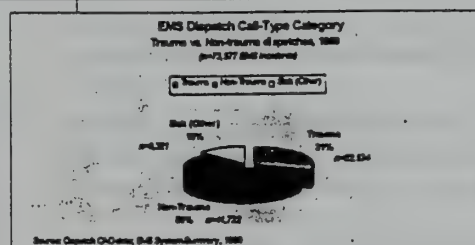
- Trauma Center Improvements in care
 - Setting National Standards
 - Trauma Recovery intervention programs
 - Basic Trauma research
- Current Innovations in Prehospital Care
 - SFFD rapid EMS response
 - Emergency Medical Dispatch Systems ²⁰

The Existing Trauma System (cont'd.)

- Primary Prevention Innovations
 - UCSF Injury Center
 - DPH Population Health & Prevention Research & Intervention Programs
 - Trauma Foundation

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The Existing Trauma System



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The Existing Trauma System

- Outcomes unknown in an estimated 40% of injured patients in San Francisco
- Need for compliance with new State Trauma (Title 22) regulations

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What are the Vulnerabilities of the Existing Trauma System?

- Trauma center capacity during high volume periods/MCIs
- Conditions affecting local & regional access to care
- Limited local resources for major pediatric trauma

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What are the Vulnerabilities of the Trauma System? (cont'd.)

- **Trauma System Organization:**
 - Limited data availability
 - Limited monitoring capacity
 - Limited quality improvement capabilities
- **Economic Vulnerabilities**
 - Growing need for infusion of Gen'l Fund \$\$
- **ED Overcrowding & Provider Staffing Vulnerabilities**

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Trauma System Needs

- **Consistently Available, Comprehensive Trauma Resources**
- **Timely Access to Appropriate Trauma Care for all victims of major injury**
- **Comprehensive Pediatric Trauma Care**

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Trauma System Needs (cont'd.)

- **System-Wide Oversight:** data collection, monitoring, quality improvement & cost-effectiveness
- **Reduction in Financial Vulnerability**
- **Open Emergency Depts.**
- **Comprehensive specialty staffing**

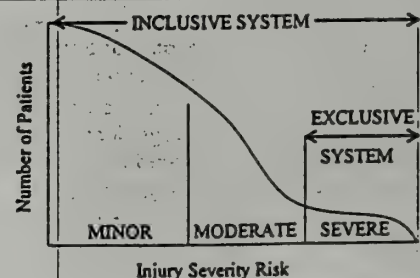
28

The Future of Trauma Care in San Francisco--a Paradigm Shift

- **Systematic, evidence-based evaluation of options**
- **Regional approach to trauma resources**
- **Inclusive trauma system**
- **Early identification of system staffing and training needs; proactive system modifications**

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Scope of Trauma Care System



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Regional Trauma Care System Plan, 1992, HRSA, DHHS

What are the Changes
in the 2001 Plan?

- Improving & Expanding Trauma System Cohesiveness
 - "Inclusive", system-based v. trauma center-based
- Address Critical Patient Transport Needs
 - Systematic evaluation of options, including emergency medical air access

What are the Changes
in the 2001 Plan?

- Improved System Oversight & Monitoring
 - Development of Trauma Audit Committees
 - Trauma System Coordinator
 - Development of systematic evaluation processes with data collection, analysis, reporting & quality improvement

What are the Changes
in the 2001 Plan?

- Evaluate & plan system response for MCI or SFGH incapacity
- Plan for comprehensive care of the pediatric trauma patient
- Address & evaluate threats to provider staffing needs

Resources Needed to Implement
the Trauma Plan

- EMS Trauma Personnel
 - Trauma Coordinator & Data Processing Support
- Data reporting by individual system providers
- Trauma System consultation
 - Trauma System development & QI expertise; Database construction expertise
 - Medical Air Access Feasibility Analysis

Projected Financial Impact

COSTS	BENEFITS
• EMS Section positions	• Fulfilling all State reqs. for data collection
• Development & maintenance of EMS/Trauma Database	• More accurate triage; less transfers
• Data collection from all system components	• Potential increase in Trauma Center revenue
• Consultants	

What do the Changes Mean to
You?

- Development of Trauma Audit Committee (TAC)
 - Quarterly meetings
 - Involving all Trauma System stakeholders
 - Monitor system structures and process
 - Data collection will parallel State reqs.
 - Timely data analysis to hospitals
 - Systematic evaluations of options for improvements to trauma system

What do the Changes Mean to You? (cont'd.)

- **Development of Medical Audit Committee**
 - Quarterly meetings
 - Trauma providers only
 - Ensure confidentiality
 - System-wide provider case reviews
 - Outcome monitoring

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Trauma Plan Approval Process

- Internal DPH meetings
 - SFGH JCC
 - CHN JCC
 - PHP JCC
 - Director's cabinet
- Stakeholder groups
- EMS Section public comment process
- EMS Section Advisory Committees
- Health Commission approval
- California EMSA approval

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Schedule

- Six-week public comment period ended May 8th
- JCC/CHN July 31st
- Health Commission August 7th
- EMS Authority August 12th

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Current Status

- **Public Comment Draft complete**
- **Revisions based on stakeholder input**

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Document Location

- EMS Section Web Site:
www.dph.sf.ca.us/ems
- Questions/comments
 - John Brown, M.D., Medical Director
 - 554-9960
 - Michael Petrie, EMS Administrator
 - 554-9972
 - Kate Garay, Trauma Project Coordinator
 - 554-9970

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Summary

- **What is the Trauma Care System Plan?**
- **What's new in the 2001 Plan?**
- **What do the changes mean to you?**

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Comments/Discussion	



CITY AND COUNTY OF SAN FRANCISCO

TRAUMA CARE SYSTEM PLAN 2001

BACKGROUND AND SUMMARY

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BACKGROUND AND SUMMARY

INTRODUCTION

The 1990 San Francisco County Trauma Care System Plan is being revised to address current Trauma System strengths and vulnerabilities, and to reflect compliance with recent changes in California State Trauma regulations. This Executive Summary provides a brief history of the trauma system, an overview of current strengths and vulnerabilities, a summary of the Trauma Plan 2001 goals and objectives, and a summary of proposed changes to the existing Trauma Plan.

BACKGROUND AND PURPOSE

In the last 50 years, research in the treatment of injured soldiers and civilians has produced mounting evidence to suggest that seriously injured patients are best served by a well-integrated system of care that activates specialized resources on a moment's notice, and provides expert, definitive treatment within an hour [1]. Although estimates vary, some studies have found preventable deaths to range as high as 20-40 percent of deaths due to injury in areas without an organized system of trauma care [2]. Though further work with sophisticated study designs is needed to make definitive conclusions, a recent report of evaluated studies of trauma care cites consistent demonstrated improvements to the survival of hospitalized patients when high standards of trauma care are incorporated [3]. This translates into nationwide annual estimates of approximately 20,000 to 25,000 lives saved [4].

In addition to progress in acute trauma care, the results of injury prevention research and programmatic activity over the last 30 years has shed light on injury risk factors, mechanisms, and effective means to reduce injuries [5]. Morbidity and mortality from gunshot wounds declined substantially in the United States during the last decade [6], and national death rates due to occupational injuries and motor vehicle injuries have been steadily declining over the last 25 years [7], [5, p. 116].

San Francisco's Trauma Care System Plan describes the framework and establishes priorities to reduce disability and loss of life due to injuries within the San Francisco Emergency Medical Services (EMS)/Trauma system jurisdiction. The Trauma Care System Plan is intended to be a working document that provides a blueprint for integration of EMS and Trauma System organizational structures and processes. It describes the goals and objectives that will guide a collaborative process of continuous enhancement of the Trauma System, using input from system stakeholders, systematic review of pertinent data, and an ongoing process of quality improvement. The standards and regulations promulgated by the Trauma Care System Plan are developed in collaboration with system stakeholders via the public comment process overseen by the EMS Section of the City and County of San Francisco's Department of Public Health. The EMS Section, under the authority of California State statutes enforces compliance with these standards and regulations.

BRIEF HISTORY—Development and Structure of the Current Trauma System

On August 1st, 1849, John W. Geary was unanimously elected the “First Alcalde” (mayor) of San Francisco. In a stirring oratory that day, he described the state of public affairs:

“At this time we are without a dollar in the public treasury, and it is to be feared the city is greatly in debt. You have neither an office for your magistrate, nor any other public edifice. You are without a single police officer or watchman, and have not the means of confining a prisoner for an hour; *neither have you a place to shelter, while living, sick and unfortunate strangers who may be cast upon our shores* or to bury them when dead. Public improvements are unknown in San Francisco. In short, you are without a single requisite necessary for the promotion of prosperity, for the protection of property, or for the maintenance of order.”
[8, p. 230 (emphasis added)]

From the anarchy of San Francisco’s early years emerged an integrated public health system of “Receiving Hospitals”, beginning in the mid-1870’s with a single “Accident or Receiving Hospital” consisting of three rooms, located in a prison. Prior to 1896, when the Department of Public Health acquired its first ambulance, patients were transported in taxis, or police patrols. Additional Emergency Hospitals were opened at the turn of the century, and through the 1930’s this network was expanded to total seven hospitals, each equipped with an ambulance, treatment rooms, wards, an operating room, and administered by a Chief Surgeon under the authority of the Director of Public Health [9].



Horse drawn ambulance at Mission Emergency Hospital, 1915²[10]

BACKGROUND AND SUMMARY

By the mid-1940's an orderly plan for care of injured patients was in place in San Francisco, as described in an historical sketch of the Department of Public Health Emergency Hospital Service during that period [9, p. 3]:

"In the event of a major accident, as a result of which a large number of injured persons must be handled in a short period of time, police patrols and private ambulances are called into service. Regardless of the district from which the ambulance is called, all cases are taken to the Emergency Hospital of the district wherein the accident occurs unless it is known that that hospital is already working at capacity load."

In the late 1960's when the results of medical research on the battlefields of Korea and Vietnam began to influence civilian trauma care in the United States, Dr. William F. Blaisdell at San Francisco General Hospital (SFGH) directed innovations in the City's trauma care system. Staffed by surgeons from the University of California, SFGH received National Institute of Health (NIH) grant funding and became a NIH designated trauma research center in 1972. Throughout the 1970's and 1980's SFGH's surgical staff played pivotal roles in setting the standards of care in many areas of traumatic injury.

Citywide acute care resources were consolidated in 1983, when all of the Public Health Emergency Hospitals were closed, with the exception of Mission Emergency Hospital (now a part of SFGH). That year, the single public health hospital in the City was designated by EMS Section Ambulance Destination policy as the sole recipient of major trauma patients. The 1990 San Francisco Trauma System Plan proposed that SFGH be designated as a Level I trauma center. This was approved by the Health Commission and the State EMS Authority that year, and SFGH was officially designated the Level I trauma center in 1991, after verification by the American College of Surgeons.

Structure of the Current System

Through the 1990's San Francisco General Hospital's Trauma Center has continued to develop its programs in clinical care, rehabilitation, functional recovery and violence prevention. SFGH remains the sole trauma center in San Francisco today, and retains Level I designation. The Department of Public Health retained direction of its citywide ambulance response system until 1997, when the function of the Paramedic Division was transferred to the San Francisco Fire Department. With activation of the multi-lingual 911 Emergency Dispatch system, severely injured patients are transported by EMS protocol to the trauma center. The EMS Division of the San Francisco Fire Department responds to the majority of trauma-related calls. The current system is trauma center-based, with quality improvement activities focusing on the prehospital, emergency and acute care of the most severe injuries.

UNIQUE CHARACTERISTICS of the SAN FRANCISCO ENVIRONMENT

San Francisco's geography and demographics, organizational and political structures, and the medical environment each have unique characteristics related to trauma system planning.

Geography and Demographics

San Francisco is bordered on three sides by bay and ocean waters. It is a cultural and financial center with an expanding population that is confined to a 47-square mile peninsula. In the last decade, population density increased by 13% from 15,000/sq. mi. to 17,000/sq.mi. [11, 12]. Compared with the twenty most populated cities in the United States, San Francisco's population density ranks second only to that of New York City [13], [14].

The Trauma System service area extends to the south, over the border of San Francisco County, to include the northern sector of San Mateo County¹. The diverse San Francisco resident population base of 801,400, with 276,900 persons from northern San Mateo County brings the Trauma System base population to 1.1 million [12]. The numbers of San Francisco visitors and commuters bring the total catchment population to an estimated 1.4 to 1.6 million [14].

Organizational and Political Structures

The organizational structures of the Trauma Care System that provide the majority of trauma-related services are governmental departments of the City and County of San Francisco, under the direction of the Mayor (see organizational chart, p. 17). These essential service provider agencies include the Emergency Communications Department, the Fire Department and the Department of Public Health (DPH). The Director of DPH provides overall direction for the City's sole trauma center and the trauma system regulatory agency (the EMS Section). The Department of Public Health and the Fire Department report to the Health Commission and the Fire Commission, respectively. The Mayor appoints seats on these commissions. Elected officials and their appointments within the governing bodies influence funding and policy decisions for the trauma system.

While under the direction of the Department of Public Health, the EMS Section must carry out its regulatory function as authorized by California State statutes (Title 22). This includes the planning, implementation and evaluation of the Trauma System. With this regulatory authority, the EMS Section enforces compliance with State statutes and local standards and policies, which have been established in collaboration with EMS Section advisory committees.

San Francisco General Hospital is also the designated Level I trauma center for northern San Mateo County residents, by agreement with the San Mateo County EMS Agency. The single trauma center is thus subject to regulatory oversight by two county EMS agencies.

¹ The San Francisco Health Commission approved this regionalization of trauma services in 1998. Trousdale Boulevard in the City of Burlingame serves as the southern boundary for this service area.

The Medical Environment—Hospitals and Physician Staffing

With its unique geography, high density, and catchment population of between 1.1 and 1.6 million persons, San Francisco continues to be served by a single trauma-designated institution-- San Francisco General Hospital. The 'City' is also served by 10 additional non-trauma center (NTC) acute care hospitals, including one University Medical Center, the University of California, San Francisco (UCSF). These institutions vary in terms of size and volume of patients, but none has ever sought trauma designation at any level, nor do any of these NTC institutions serve as backup hospitals in the event that SFGH is incapacitated or overwhelmed, except during mass casualty incidents.

The professional staffing at SFGH is composed entirely of UCSF faculty, many with clinical appointments, and a rich array of house staff (over 1000 at any one time) rotating on various primary, specialty, and sub-specialty services. Compensation for professional services provided by UCSF medical staff to SFGH is provided through a contract between UCSF and the City/County of San Francisco. Specifics of the relationship between UCSF and SFGH are further defined by an Affiliation Agreement, a 38 page document, signed in 1994, specifying a variety of responsibilities, duties, accountability, and payment methods. Under these arrangements, physician staffing levels, including house staff, are determined by each individual department according to educational opportunities and clinical needs. Under this agreement, the University (UCSF) retains sole authority to make decisions regarding the scope of clinical services provided by its faculty and house staff. The administrative hierarchies of the Department of Public Health (including SFGH) and UCSF are largely independent, and accountability for the maintenance of specific clinical services (e.g. trauma) is not defined in the current system.

STRENGTHS and VULNERABILITIES of the EXISTING SYSTEM

Single Designated Trauma Center

San Francisco General Hospital is the sole referral center for major trauma within the City. Research in trauma surgery and injury prevention, and innovations in trauma education and patient care have distinguished San Francisco General Hospital (SFGH) as one of the nation's leading trauma centers. These characteristics and the relatively high volume of trauma patients treated there, qualify SFGH to be a Level I trauma center. As such, the facility meets the highest standards promulgated by the American College of Surgeons and the State of California.

SFGH admits approximately 1,200 trauma patients per year, thus meeting the volume criterion set by the State of California for Level I trauma center designation. Should an additional trauma center exist in San Francisco, this yearly volume of 1,200 patients would be divided between two trauma centers. Such an arrangement would threaten the ability of SFGH to retain its Level I designation. A minimum volume of patients is required for the hospital staff to retain superior skills in patient management, to sustain a trauma surgery residency program, and to conduct trauma research—all of which are requirements for Level I designation.

Capacity Saturation

While this patient volume, on average, is sufficient to support the maintenance of superior provider skills without taxing the Trauma Center's service capacity, there are occasions when the single Trauma Center receives multiple unrelated cases in a short time interval, and trauma service capacity is saturated. On a busy weekend night, for example, multiple (five to seven) critically injured patients could arrive at the trauma center within a short period of time (one to four hours). On occasion, this can and does employ the staff and equipment in the critical trauma treatment areas to full capacity. There is no system of "back-up" in place for the single trauma center. There is no other designated facility in San Francisco that is qualified to care for severely injured patients. While other community hospitals have surgeons and operating rooms, the specialized personnel, equipment, policies and procedures necessary to deliver standard trauma care are not available in any other hospital but SFGH. In a service area of over one million population, there is only one Level I trauma center, and no Level II, III or IV designated centers available for "back-up" care of major injuries.

Environmental, Geographical and Medical Transport Constraints

Local and national standards for trauma care mandate that patients have access to specialized trauma treatment services within one hour of the injury. Code 3 (lights and sirens) ground ambulance service within the immediate trauma system service area currently meets this standard in the majority of trauma cases. The average time interval from initial call to Code 3 arrival at the trauma center is roughly thirty minutes.

Emergency medical transportation to and from the trauma center is limited to ground transportation. Ground routes include a freeway commute thoroughfare, and surface streets in a busy urban neighborhood. The trauma center has no helipad, and there is no licensed medical helipad in San Francisco. As previously described, San Francisco is a very densely populated urban region, bordered on three sides by large bodies of water. Access and egress to the north and east of San Francisco by ground transportation is limited to bridge routes that are chronically congested². Ground transportation routes to the south are more varied, yet these are also increasingly congested. An ad-hoc helicopter landing site at Pier 94-96 is used on an emergency basis, but the lack of security, poor access conditions, and additional transport time via ground to the trauma center adds risk to trauma patients and emergency medical providers.

Multiple Casualty Incident Risk—Natural and Geopolitical

As one of the highest-density, most earthquake-prone regions in the world, San Francisco is vulnerable to a wide range of small and large-scale multiple casualty incidents. These include traumatic incidents common to urban environments such as airplane, mass transit and freeway

² As a measure of urban traffic congestion, the Texas Transportation Institute examined traffic patterns in 68 urban areas of the United States [16]. In 1999, the San Francisco-Oakland commute ranked second (after Los Angeles) in the Travel Rate Index, which measures the amount of additional time needed to make a trip during a "normally congested" peak travel period rather than at other times of the day.

BACKGROUND AND SUMMARY

crashes, school violence, and terrorist acts. San Franciscans are also very familiar with the threats of natural disasters such as earthquakes and fires.

Pediatric Trauma

Another vulnerability of the trauma system in San Francisco stems from the fact that the pediatric population is proportionately small. The annual pediatric trauma volume at the Trauma Center is not large enough to allow the accumulation of sufficient experience to be able to consistently provide a high level of care to very young victims of critical injury. For example, a three-month-old infant with crush injuries to the head and chest requires a higher level of expertise from multiple trauma care providers than does an eight-year-old with a single injury to the spleen. The younger, more severely injured patients (roughly two to four per year at SFGH) require a higher level of trauma care in a designated pediatric trauma center.

Trauma System Organization—Limited Oversight and Quality Improvement Processes

The trauma system in San Francisco is "Trauma Center-based". As such, there is limited monitoring of the structures, processes and outcomes for care of the most severely injured patients. Trauma Center re-designation and overall system evaluation are regulatory functions of the EMS Section, yet there is no formal process established for an ongoing trauma system evaluation. The trauma center conducts a standard performance improvement process to monitor all admissions. Prehospital trauma care is monitored by the EMS Section with a system of unusual occurrence reporting and analysis conducted in collaboration with EMS advisory committees. Beyond these elements, there is no direct linkage of data or formal oversight process for related components of trauma care, which include injury prevention research and program activities, pre-hospital death records, rehabilitative care, or care of injured patients in community hospitals. Within the current organization, there is limited information available for accurate assessment and ongoing improvement of the trauma system.

Economic Vulnerabilities

Over the past decade, throughout California and the United States, trauma centers have experienced intense fiscal pressure because significant proportions of their services have been uncompensated. While maintaining the specialty services, equipment, and facilities essential for trauma centers is inherently costly, funding mechanisms have been unstable. Declining reimbursements from government and private insurance sources, managed care contract discounting, unstable federal, state and local funding, and relatively high proportions of uninsured trauma patients have forced the closure of trauma centers in many systems across the United States. In a 1993 national survey of trauma centers at the beginning of "health care reform" with managed care, 58% reported serious financial problems, and 68% reported financial losses [17]. A recent survey of trauma centers in California estimates that 30% of patients are uninsured [18].

San Francisco's trauma center is not unique in this portrait of the current crisis in trauma care funding. With declining reimbursement rates and shrinking state and federal funding, there is mounting reliance on local taxpayer revenue for trauma care support. The California State

legislature has several bills pending that propose to bolster funding support for trauma systems throughout the State. Should this legislation pass, there will be a measured allocation of funds to San Francisco's trauma system. Whether the legislation will pass, and how much funding will be available is uncertain. The proposed amount for allocation is estimated to be a small fraction of what is needed to ensure trauma center funding stability.

Regional and Local Limitations of Acute Care Resources

Inpatient Capacity Shortfall

Hospital closures, mergers and downsizing in the past several years have significantly reduced the availability of inpatient hospital beds in San Francisco and throughout the United States. Nationally, the number of medical/surgical beds declined by 18 percent between 1994 and 1999, and the number of intensive care unit beds declined by almost 3 percent [19]. Anticipating lower utilization under managed care and declining reimbursement from private payers and Medicare, many hospitals have extensively reduced inpatient capacity. Concurrently, inpatient volume has increased, resulting in critical constraints on hospital inpatient unit capacity.

Emergency Department Utilization and Overcrowding

An indirect measure of this hospital bed capacity shortfall in San Francisco is the number of hours per month that emergency departments must close to ambulance traffic (ED Diversion Hours). Since 1995 there has been a steady upward trend in the total average number of hours per month that emergency facilities have had to divert ambulance traffic [21], [21], [22]. This local trend reflects the national burden on hospital emergency departments. A recent report from the National Center for Health Statistics [23] cites a 14% increase in Emergency Department (ED) utilization nationwide from 1992 through 1999. The report describes a steady rate of ED visits per population since 1992, but the number of hospitals with EDs has not kept pace with a growing population. Similarly, in the last decade, San Francisco has seen a population increase of 9%, and a closure of three hospital emergency departments [24] [12].

Reduced Trauma Center "Unusual Volume" Capacity

In this setting of reduced inpatient resources and ED overcrowding, the trauma system is recurrently pushed to capacity limitations. There are very few surplus trauma center resources with which to manage the unusually high patient volume that can readily be foreseen, for example, in the event of a rolling blackout-induced multiple car crash, or other multiple casualty incidents. Constrained inpatient/ED resources has forced steady erosion in emergency "stand-ready" capacity that the trauma system needs to manage unusually high volume.

Provider Staffing Vulnerabilities—Nursing & UCSF Faculty/Residents

Nursing

While demand for inpatient beds remains strong, many San Francisco hospitals cannot hire enough nurses to keep existing beds in operation. This is due in part to a nationwide shortage of nurses, particularly acute in California, and to the high cost of housing in the San Francisco Bay

Area. At a hearing before the Public Health and Environment subcommittee of the San Francisco Board of Supervisors in May, 2001, community hospital representatives cited marginal success with concerted efforts to hire registered nurses (RNs), and difficulty retaining them because the RNs could not find affordable housing [25]. The 2000 National Sample Survey of Registered Nurses found California to rank 49th among the 50 states in the number of employed RNs per capita³ [26]. The California Strategic Planning Committee for Nurses predicts a shortfall of 25,000 nurses within the next five years [27].

UCSF Faculty and Residents

The relationship between UCSF and SFGH is a symbiotic one. The University provides high quality medical staffing to the hospital while SFGH provides the infrastructure for a rich and varied clinical practice. SFGH serves as a base for ongoing research, graduate, and post-graduate medical education. The primary missions of UCSF and SFGH are not identical. The former emphasizes education and scholarly activity while the latter emphasizes service and clinical care. The vulnerability with respect to the goal of consistently providing Level I trauma services at SFGH is created by the fact that the current agreement between the University and SFGH specifically states that the University has sole authority over decisions regarding staffing for clinical services. In the event that a significant staffing change is made, the agreement requires only notification by the University. There is no other agreement that serves to prevent or forestall the University from taking abrupt unilateral and independent action that compromises the ability of SFGH to function as a Level 1 Trauma Center. While it is highly unlikely that the University, as a matter of policy, would ever condone intentional actions designed to degrade or compromise the function of the Trauma Center at SFGH, there is also little protection in the present system from unintentional or collateral actions that, in effect would do the same thing.

³ According to this survey, the national average of RNs per capita is 782 per 100,000 population. California has 544/100,000.

GOALS and OBJECTIVES of the TRAUMA CARE SYSTEM PLAN 2001

The following goals and objectives of the San Francisco Trauma Care System Plan were developed during a public comment process conducted March through May, 2001. They are directed toward reducing the vulnerabilities of the trauma system.

Goal I: To ensure a high standard of trauma system care in San Francisco.**Objectives:**

- A. Establish a Trauma Audit Committee that will, at the direction of the EMS Section,
 - 1. Include representative administrators and providers from the inclusive trauma system in San Francisco;
 - 2. Develop and regularly evaluate trauma system quality indicators;
 - 3. Develop a data collection process (database centralized in the EMS Section with the EMS Trauma Registry), that links data from the following trauma system structures:
 - a) prevention research and program databases, b) medical examiner, c) communications, d) prehospital care, e) trauma center, f) community hospitals, and g) rehabilitation facilities;
 - 4. Monitor and analyze system-wide trends in process and outcome data from trauma system structures;
 - 5. Establish a regular process of trauma system evaluation and issue an evaluation report every two (2) years;
 - 6. Continuously plan for, and implement changes in the trauma system according to evaluation results, and in accordance with the goals of the trauma system.
- B. Continue to enforce local, State and Federal standards and regulations that apply to trauma system care in San Francisco.
 - 1. Evaluate trauma center for re-designation in 2002 and continue with re-designation process every three (3) years;
 - 2. Establish and maintain an EMS Section Trauma Registry that is linked to the State EMSA Trauma Registry;
 - 3. Develop and staff Trauma Audit Committee and Trauma Medical Audit Committee;
 - 4. Submit Trauma System evaluation reports to system stakeholders every two (2) years, commencing in June, 2002;
 - 5. Submit an annual trauma system status report to the California State EMSA [Title 22, Div. 9, Chp. 7, §100253(j)].

Goal II: To promote continuous improvement in the physical and psychosocial outcomes of significant injury in San Francisco.**Objectives:**

- A. Develop a Trauma Medical Audit Committee that will:
 - 1. Include trauma care providers—prehospital, acute care, rehabilitative;
 - 2. Include providers from all hospitals that receive acutely injured patients;

3. Regularly audit all trauma-related deaths, major complications and transfers (including interfacility transfers);
4. Develop and regularly evaluate trauma care quality indicators for physical and psychosocial outcomes of traumatic injury;
5. Conduct its proceedings in accordance with all local, State and Federal statutes related to provider and patient confidentiality and privacy;
6. Provide input to the Trauma Audit Committee for trauma system evaluation and quality improvement activities;
7. Promote proactive education and training for trauma care providers.

Goal III: To ensure the consistent availability of rapid access to an appropriate level of trauma care for injured persons in the San Francisco Trauma Care System service area, and for San Francisco residents injured in neighboring regions.

Objectives:

- A. Establish a plan for trauma center "backup" to ensure standard care for injured persons in the event of trauma center capacity saturation, plant disruption, or local multiple casualty incident;
- B. Complete a needs assessment and feasibility study for an EMS helipad in San Francisco;
- C. Develop EMS Section Emergency Air Medical Plan.
- D. Develop a formal agreement with UCSF that will help guarantee the availability of medical staffing commensurate with the requirements of a Level I Trauma Center.

Goal IV: To ensure a seamless system of pediatric trauma care in San Francisco.

Objectives:

- A. Ensure development of SFGH trauma center policy for expedient transfer of critically injured younger pediatric patients to a designated pediatric trauma center;
- B. Incorporate regional pediatric trauma centers into HART system;
- C. Standardize pediatric trauma care protocols (including transfer protocols) throughout the EMS System;
- D. Improve all hospitals' Emergency Department Pediatric Trauma Care Plans.

Goal V: To promote a decrease in injury rates in San Francisco.

Objectives:

- A. Through the activities of the Trauma Audit Committee,
 1. Improve communication between San Francisco injury research, treatment, prevention and education programs;
 2. Develop data linkages with research, prevention and treatment programs in San Francisco;
 3. Promote prevention education programs for providers and the public.

Goal VI: To do all of the above in a cost-effective manner, sensitive to existing and available resources.

Objectives:

- A. Avoid duplication of Trauma System data collection efforts by including all system stakeholders in development and implementation of the data collection process;
- B. Establish regular, timely reporting of data analysis to all system stakeholders;
- C. Use existing Department of Public Health resources to implement and maintain the Trauma System data collection process;
- D. Maximize the use of trauma system triage capabilities so that unnecessary interfacility transfers are minimized, where:
 - 1. Injured patients who do not require trauma center evaluation or treatment are transported immediately from field to patron hospitals; and
 - 2. Injured patients who do require trauma center evaluation/treatment are transported immediately to the trauma center.
- E. Continuously evaluate the fiscal impact of the trauma system and submit a fiscal impact report every two (2) years with the Trauma System Evaluation report.

REVISIONS to the 1990 TRAUMA CARE SYSTEM PLAN

The 2001 Trauma Plan incorporates changes to system structures, design, policies, data collection and evaluation processes, that will strengthen the system, and provide broader, more consistent oversight of structures, processes and outcomes.

Changes to Organizational Structures and Relationships

Development of the San Francisco Trauma Audit Committee (SF_TAC) and the Trauma Medical Audit Committee (SF_TMAC) will incorporate the majority of organizational changes. The Trauma Audit Committee will establish a key link between the various provider, administrative, research, education and regulatory structures of the trauma system. This committee will be tasked with ongoing evaluation and policy development for the trauma system, under the direction of the EMS Section.

The Trauma Medical Audit Committee (SF_TMAC) will provide a confidential forum for local and regional medical review of trauma cases, and link with the SF_TAC to provide input for ongoing system evaluation. (See pages 18 and 19 for organizational charts.)

Trauma System Design

In the 2001 revision of the Trauma Care System Plan, there is a conceptual shift in the trauma system design, from trauma center-based to an inclusive model. This will be reflected in changes in the trauma system data collection, evaluation and policy development processes with the formation of the SF_TAC and SF_TMAC. The single Level I trauma center in San Francisco remains the locus of acute care for severely injured patients. There is no plan to designate an additional trauma center.

What's an Inclusive Trauma Care System?

An inclusive system is organized and coordinated in a defined geographic area to deliver the full spectrum of care to an injured patient, from the time of the injury through transport to an acute care facility, to rehabilitative care, and reintegration at work and home [5]. In this type of system, the trauma center remains a key component, but the necessity of other health care facilities is also recognized.

An overarching goal of a trauma care system is to match the severity of the injury to the most appropriate and cost-effective level of care in a region. This is best accomplished by an inclusive system—one that shares resources of all hospitals and trauma care providers in a community or region to meet the needs of all injured patients, the majority of whom⁴ are not severely injured. This type of resource allocation allows patients to move to the highest level of care available and ideally, avoids excessive and inappropriate resource expenditure in a time of limited medical resources [29].

Trauma Policies

Trauma policy modifications in the 2001 Trauma Care System Plan include:

1. Addition of Trauma Audit Committee and Trauma Medical Audit Committee to the Trauma System organization and management;
2. Development and maintenance of an EMS Trauma System Registry;
3. Trauma Center Quality Improvement process modifications in accordance with Title 22, Div. 9, Chp. 7, (including provision for written system of feedback for pediatric patients' families);
4. Deletion of policy for EMS Section oversight of trauma center marketing plans (1990 Trauma Care Plan, Section III, number 8 [p. 22]).

Further policy development will ensue with the formation of the SF Trauma Audit Committee. Areas for policy development include:

1. "Back-up" plan for trauma center;
2. Standardization of pediatric trauma care plans, transfer guidelines and mechanisms;
3. Incorporation of regional pediatric trauma centers into San Francisco trauma system design;
4. Emergency Air Medical Plan;
5. Interfacility transfer policy amendments [Title 22, Div. 9, Chp. 7, §100255(h), 100265, 100266] to include provisions for:
 - a. Criteria for trauma patient transfers between regional trauma centers and SFGH and from SFGH to regional trauma centers and local community hospitals;
 - b. Written transfer agreements between community hospitals and SFGH: Community hospitals to have written criteria for consultation and transfer of patients needing a higher level of care;
 - c. Data collection from community hospitals who receive repatriated trauma patients;

⁴ In 1996, 63% of traumatic injury hospitalizations in San Francisco were in "non-trauma centers"—community hospitals that are not designated trauma centers [28].

- d. Participation in trauma system quality improvement activities from community hospitals that receive transferred (repatriated) trauma patients;
6. Trauma System Evaluation and Quality Improvement Plan; including data collection process, and maintenance of trauma system registry;
 - a. Inclusion of all hospitals that receive trauma patients in trauma system data collection process [Title 22, Div. 9, Chp. 7, §100257];
 - b. Participation of all hospitals that treat trauma patients in trauma system quality improvement [Title 22, Div. 9, Chp. 7, §100258(d), 100265];
7. Individual prehospital provider policies for early notification of trauma centers impending trauma patient arrival to be approved by EMS Section.

Data Collection

The EMS Section is revising its EMS system-wide Data Collection and Quality Improvement Plan. Modifications to Trauma System data collection will be integral to the EMS System data collection process. The Trauma Audit Committee will work with Trauma System stakeholders to develop standardized quality performance indicators and data elements. Improvements to the current data collection process will be developed with stakeholder input, while avoiding duplicate data collection and minimizing expenditure of available resources.

Trauma System Evaluation

[Title 22, Div. 9, Chp. 7, §100258]

With the Trauma Audit Committee, the EMS Section will develop an ongoing process for trauma system evaluation. Elements of the evaluation will include, but not be limited to periodic review of the epidemiology of traumatic injuries, triage criteria, fiscal impact, and management of the Trauma Care System Plan, including addressing system vulnerabilities outlined in the Plan. Specifically with regard to the vulnerabilities described in the 2001 Trauma System Plan, the Trauma Audit Committee will use a data-driven process to evaluate and plan for:

- a) Optimal care of critically injured young pediatric patients in San Francisco;
- b) A response to sudden and unexpectedly large numbers of major and minor trauma patients arriving at the sole trauma center within a short period of time;
- c) Optimal care for all victims of major injury in San Francisco, including those initially transported to non-trauma center hospitals;
- d) The provision of trauma care in the event of a mass casualty event or major disaster, including transport of materials and personnel and the transport of critically injured patients out of San Francisco; and
- e) Participation of the San Francisco trauma system in regional trauma care, serving the need for Level I services.

A trauma system performance evaluation will be conducted every two (2) years at minimum, and the results will be made available to all trauma system participants.

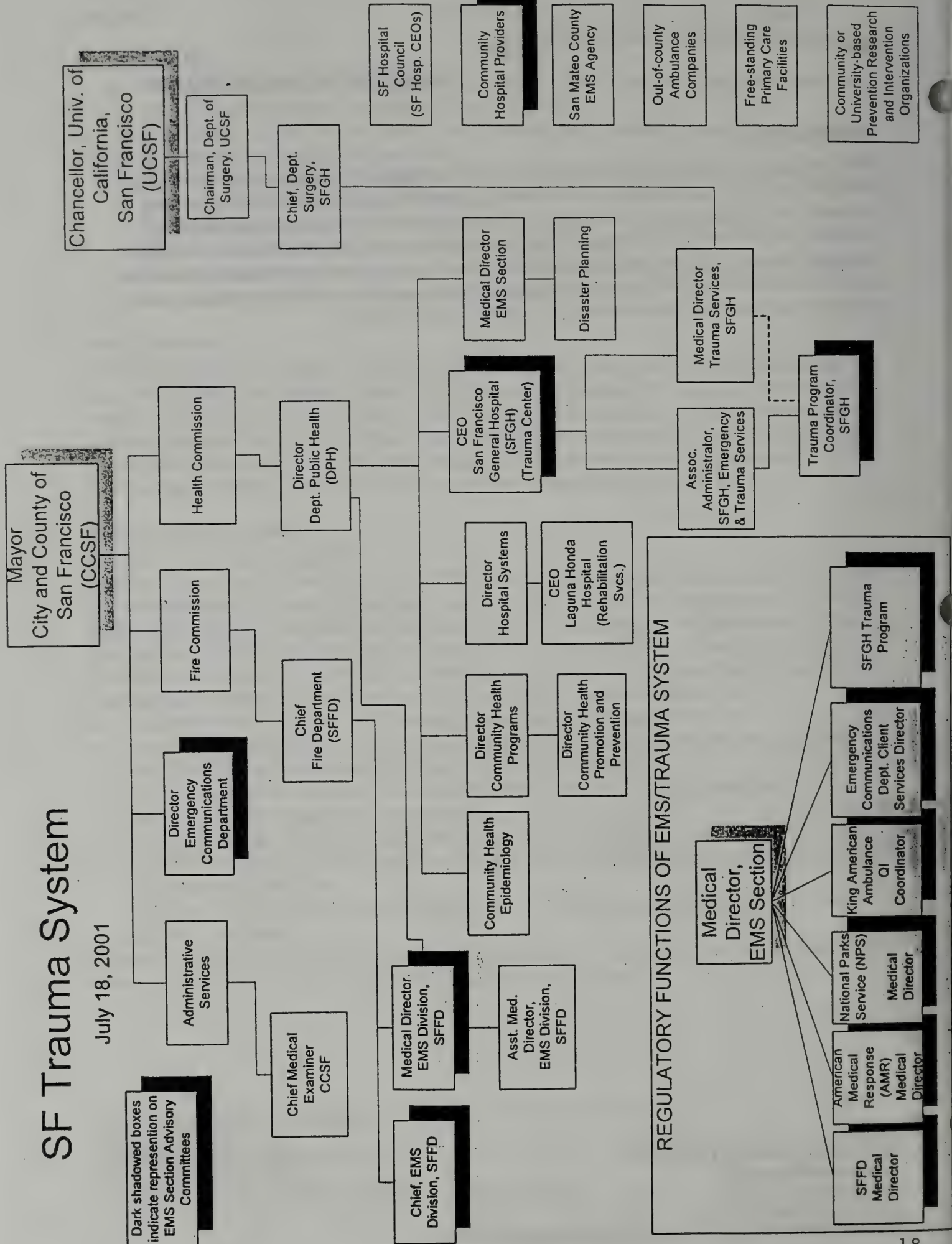
CONCLUSION

The San Francisco Trauma Care System Plan is being revised with goals and objectives that address the unique characteristics of the trauma system environment and the strengths and vulnerabilities of the system. Revisions have been incorporated after an extensive public comment process involving written feedback and meetings with key stakeholders. With the proposed changes to the trauma system organization, improved system oversight and ongoing data-driven evaluations will be available for policy decisions that will improve utilization of resources and result in reduction of injury morbidity and mortality.

SF Trauma System

July 18, 2001

Dark shadowed boxes indicate representation on EMS Section Advisory Committees



July 18, 2001

City and County of
San Francisco
(CCSF)

Dark shadowed boxes indicate representation on proposed Trauma Audit Committee

Chancellor, Univ. of
California,
San Francisco
(UCSF)

Chairman, Dept. of
Surgery, UCSF

**Chief, Dept.
Surgery.**

**SF Hospital
Council
(SF Hosp. CEOs)**

Community Hospital Providers

**San Mateo County
EMS Agency**

Out-of-county Ambulance Companies

**Free-standing
Primary Care
Facilities**

**Community or
University-based
Prevention Research
and Intervention
Organizations**

Health Commission

Director
Dept. Public Health

	Medical Director EMS Section
--	---------------------------------

Disaster Planning

Medical Director
Trauma Services,
SFGH

**Trauma Program
Coordinator,**

**Assoc.
Administrator,
SSFGH, Emergency
& Trauma Services**

CEO
San Francisco
General Hospital
(SFGH)
(Trauma Center)

Director
Hospital Systems

CEO
Laguna Honda
Hospital
(Rehabilitation
Svc.)

**Director
Community Health
Programs**

**Director
Community Health
Promotion and
Prevention**

Community Health
Epidemiology

**Medical Director
EMS Division,**

Asst. Med.
Director,
EMS Division,

Chief, EMS
Division, SFFD

Chief Medical Examiner

Administrative

**Director
Emergency
Communications
Department**

Fire Commission

City and County of
San Francisco
(CCSF)

REGULATORY FUNCTIONS OF EMS/TRAUMA SYSTEM

Note addition of non-trauma centers to EMS Section regulatory oversight. This is in accordance with Title 22 Trauma System regulations, effective 8/12/99.

**Medical
Director,
EMS Section**

SFGH Trauma Program & non-trauma centers

Emergency
Communications
Dept. Client
Services Director

King American
Ambulance
QI
Coordinator

National Parks
Service (NPS)

**American
Medical
Response
(AMR)**

SFFD
Medical
Director

Roma P. Guy, M.S.W.
President

Edward A. Chow, M.D.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

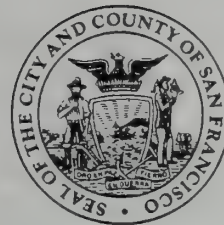
Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor
Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

Tel. (415) 554-2666
FAX (415) 554-2665

Web Site: <http://www.dph.sf.ca.us>

AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, August 14, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

AUG 14 2001

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: CONSIDERATION OF APPROVING THE MINUTES FOR JULY 24, 2001.
**Minutes of July 24, 2001*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
**Report*

- 5) **FOR DISCUSSION:** **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Gregg Sass, CHN Chief Financial Officer)
**Report*
- 6) **FOR DISCUSSION:** **INTEGRATED SOFT TISSUE INFECTION SERVICE**
(David Young, M.D., Co-Medical Director for ISIS)
**Report*

7) **CLOSED SESSION**

- A) Public Comments on All Matters Pertaining to the Closed Session**
- B) Vote on Whether to Hold a Closed Session (San Francisco Administrative Code Section 67.11(a).)
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **TO APPROVE CLOSED SESSION MINUTES OF JULY 24, 2001**

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE AND CREDENTIALING MATTERS**

Alan Gelb, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.14(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.14(a).)

8) **ADJOURNMENT**

* Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Health Commission on items of interest to the public that are within the subject matter jurisdiction of the Health Commission. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine

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Roma P. Guy, M.S.W.
President

Edward A. Chow, M.D.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

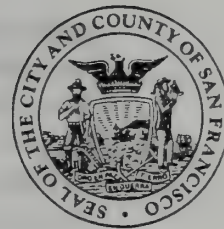
David J. Sánchez, Jr., Ph.D.
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HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL MEETING

Tuesday, August 14, 2001
3:45 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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SEP 13 2001

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1) CALL TO ORDER

The regular meeting of the San Francisco General Hospital Joint Conference Committee was called to order by Commissioner John I. Umekubo, M.D. at 3:45 p.m.

Present: Commissioner John I. Umekubo, M.D.

Absent: Commissioner Lee Ann Monfredini

Staff: Sue Currin, Mozettia Henley, John Luce, M.D., Alison Moed, J. Renee Navarro, M.D., Gene O'Connell, Gregg Sass, Cathryn Thurow, Hiro Tokubo, Chris Wachsmuth, Connie Young, and David Young, M.D.

2) APPROVAL OF THE MINUTES FOR JULY 24, 2001.

Action Taken: The committee adopted the minutes of July 24, 2001.

3) HOSPITAL HEALTHCARE UPDATE (Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)

Recruitment Efforts and Assignments

As reported at the last JCC-SFGH, Gayling Gee, Hospital Associate Administrator for Specialty and Diagnostic Services, resigned at the end of July to accept a position at Laguna Honda Hospital as a Hospital Associate Administrator for Nursing. We are currently recruiting for a new Hospital Associate Administrator. With the understanding that recruitment of this high level position takes time and consideration, areas which used to report to Gayling Gee have been reassigned to various Hospital Associate Administrators in the interim so to provide them the administrative support they require. The majority of the assignments are interim; however there are a few departments which will now permanently report to the reassigned Hospital Associate Administrator. The changes are as follows:

<u>Department</u>	<u>Assigned Hospital Associate Administrator</u>
3M, 4M, 1N, 4C	Sue Currin (Permanent)
Cardiac Cath Lab	John Kanaley and Sue Currin
Clinical Laboratory and Pathology	Christine Wachsmuth
Infection Control	John Kanaley
Medical Specialty Clinics Liaison	Christine Wachsmuth
Perioperative and Anesthesia	Sue Currin (Permanent)
Radiology and Nuclear Medicine	John Kanaley

Accordingly, the San Francisco General Hospital Medical Center organizational chart has been changed to clearly reflect the permanent changes. The organizational chart also reflects for which areas the new administrator will have responsibility.

The position has already been posted on the DPH web site and will also be advertised in the local newspapers. It is hoped to begin interviewing in the beginning of September 2001 and hire by the end of September.

Avon Grant – Women's Imaging Center

The June 26, 2001 Avon site visit to San Francisco General Hospital Medical Center was a great success! Avon representatives were very impressed with the overall facility and vision for the Women's Imaging Center. During the site visit, Avon representatives, SFGH Foundation representatives, and SFGHMC representatives visited the 6C Birthing Center, 6H Nursery, and the Department of Radiology. In addition, they visited the site where the proposed Women's Imaging Center would be located (by the current Volunteer's Office).

Many thanks to Dr. Judith Luce, Dr. Margeret Knudsen, Dr. Ernie Ring, Diane Carr- PHP Women's Services, the Patient Navigators, and Susan Jacobson, Director of the SFGH Foundation and her staff, for all of their hard work and dedication to this grant and visit.

Employee Recognition Ice Cream Social

The employee recognition ice cream social held on June 26th was a huge success! Hundreds of employees turned out to the main quad to enjoy ice cream, dancing, and a karaoke contest. Many thanks to CHEARS for all of their hard work!

Joint Commission on Accreditation of Health Care Organizations (JCAHO) Mock Survey

Steven Hirsch and Associates will be conducting a JCAHO mock survey at San Francisco General Hospital Medical Center during the week of September 10th. SFGHMC staff met with Mr. Hirsch and his staff is all current JCAHO or IMQ surveyors. In addition to looking at the JCAHO and IMQ standards during the mock survey, he will also be cross-referencing Title 22 standards,

something which has not been performed in past mock surveys and will be very beneficial to SFGHMC in preparing for the Consolidated Accreditation and Licensure Survey (CALs), which involves JCAHO, IMQ, and DHS.

Ms. O'Connell will continue to update the JCC-SFGH as the schedule for the mock survey becomes finalized.

Patient Flow

Optimizing patient flow remains a very critical issue to San Francisco General Hospital Medical Center and for this reason, it is continually monitored and reported into the Director's Cabinet on a weekly basis. We continue to work collaboratively with Community Mental Health Services (CMHS) and Laguna Honda Hospital to address the issues connected to patient flow. Following is the most recent patient flow report presented to the Director's Cabinet.

SFGHMC PATIENT FLOW REPORT **August 13, 2001**

<u>SFGH Current Census (7:00 a.m.):</u>	339	
<u>SFGH Budgeted Census:</u>	292	
Med-Surgical	214	(budgeted 180)
• Critical care (4E & 5E/R)	23	(budgeted 21)
• 4B	18	(budgeted 21)
Psychiatry	97	(budgeted 92)
SNF	28	(budgeted 20)

Number of Patients Waiting for Beds:

ED	1 (Floor)
PACU	2 (4B)
PES	1

Total: 4 Patients Waiting for Beds

For week of 8/06 - 8/13: 0 patients waited more than 24 hours in the Emergency Department

Number of Patients/Residents Accumulating Decertified Days:

Medical-Surgical

15 Needs placement at LHH

- 2 patient waiting in 4A for LHH approval
- 10 patients waiting in 4A - accepted by LHH and waiting for beds
- 2 patient being evaluated by LHH
- 1 patient accepted to LHH, waiting for bed

1 Referred to Bridge Committee

9 Needs 4A

- 6 approved and waiting for 4A bed availability
- 3 awaiting 4A approval

4 Needs community placement

- 1 patient will refer to Broderick (refused by LHH)
- 1 needs residential hotel
- 2 need Vencor placement

2 Other Issues

- 1 newborn boarding; mother with cellulitis
- 1 needs IV amphi

4 Delay of Service for X-rays/MRI

Total Medical Surgical Patients Identified: 35

Psychiatry

3 Needs LHH Placement

- 1 is waiting for bed at LHH
- 1 has been refused by LHH- appealing decision
- 1 referred to LHH after being refused by MHRF

2 Needs MHRF Placement

- 2 are waiting for MHRF beds

7 Needs Community Placement

- 2 are waiting for ADU beds
- 1 is waiting for a RCH bed
- 1 is waiting for a bed at Crestwood Fremont
- 1 is waiting for a Napa Bed
- 1 is waiting to be reconsidered by Crestwood Fremont-
will likely require Napa Bed
- 1 LHH vs. RCH bed

3 Waiting for CMHS

- 1 is waiting for decision from CMHS bed committee regarding long term care
- 1 is having a CMHS case conference on Friday, August 10
- 1 is waiting for a decision from CMHS regarding an appeal

1 Waiting for Bridge Committee

- 1 is waiting for a decision from the Bridge Committee

Total Psychiatry Patients Waiting: 16

Total Lost Revenue for 8/06-8/13: \$405,500

Mental Health Rehabilitation Facility

Current Census:	147 beds (including 6 bed holds)
Budgeted Census:	140 beds
Capacity:	147 beds

35 identified as needing community placement

- 7 waiting for residential treatment
- 9 monolingual residents for Broderick House; placement for those not accepted has not been identified
- 9 Broderick House – medical component
- 10 awaiting residential treatment placement

1 identified for Laguna Honda

Admissions since 8/06/01: 2 admits

Discharges since 8/06/01: 0

Total Identified at MHRF for Placement: 36

Overall Total of Decertified Patients/Residents: 87

- SFGHMC Patients/Residents Waiting for LHH: 19
- SFGHMC Residents Waiting for MHRF 2
- SFGHMC Patients Waiting for CMHS 3
- SFGHMC Patients Waiting for 4A 9
- SFGHMC Patients/Residents Waiting for
Community Placement 46
- SFGHMC Patients Referred to Bridge Committee 2
- Other Issues 2
- Delay in Service 4

Commissioners' Comments

- Commissioner Umekubo commended Ms. O'Connell for including patient flow information in her Director's Report, and stated that this information is helpful and should be discussed further in the future.

4) PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)

Ms. Currin presented the Patient Care Report (Attachment A). As part of the report, Ms. Currin presented at summary of activities taken to decrease diversion at San Francisco General Hospital.

5) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)

Mr. Sass submitted the Statement of Revenue and Expenses ending July 31, 2001, and the Summary Statistical Information ending July 31, 2001 (Attachment B).

6) INTEGRATED SOFT TISSUE INFECTION SERVICE
(David Young, M.D., Co-Medical Director for ISIS)

Dr. Young presented a report on the Integrated Soft Tissue Infection Services (ISIS) Clinic (Attachment C).

7) **GENERAL PUBLIC COMMENT ON ANY MATTER WITHIN THE SUBJECT MATTER JURISDICTION OF THE JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL**

None.

8) **CLOSED SESSION**

A) Public Comments on All Matters Pertaining to the Closed Session

None.

B) Vote on Whether to Hold a Closed Session (San Francisco Administrative Code Section 67.11.)

Action Taken: The Committee voted to go into Closed Session at 5:25 p.m.

Individuals present in the Closed Session were the same as in the Open Session, except for Gregg Sass, Cathryn Thurow, and David Young, M.D.

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

Action Taken: The Committee approved the Closed Session Minutes of July 24, 2001.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE AND CREDENTIALING MATTERS

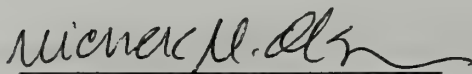
The Committee came out of Closed Session at 6:00 p.m.

D) Reconvene in Open Session

Action Taken: The Committee voted not to disclose any discussions held in Closed Session (San Francisco Administrative Code Section 67.12 (a).)

8) **ADJOURNMENT**

The meeting was adjourned at 6:00 p.m.



Michele M. Olson
Health Commission Secretary

Attachments (3)

- E. **Morning Report** at 7:30 a.m. now includes Charge Nurses/Nursing Directors from PACU/OR, Critical Care, Step Down, Emergency Department and Perinatal Services. The report is used to review the current bed status, determine the strategy for effective utilization of resources, and to facilitate patient flow by planning priority admissions, transfers and discharges.
- F. A **Resource Roving Registered Nurse** is assigned to work 10:00 am to 10:00 pm, 7 days per week. The need for this position was identified when high Admission-Discharge-Transfer (ADT) rates were experienced in Med-Surg as a result of the increased the patient flow. This Resource Roving Registered Nurse is deployed by pager and the Administrator on Duty to meet the challenges of providing safe, appropriate, and timely care to patients.
- G. **Transitional Temporary Work Assignment (TTWA)** nursing staff are centralized under the Nursing Director-Operations. The Nursing Director works closely with Worker's Compensation and ADA staff to deploy TTWA staff to areas and shifts that accommodate their work restrictions and meet the needs of the Hospital.
- H. The **Registry Contract** has been expanded to increase the access to more agencies providing RN and LVN staffing. The contract will be presented to the Health Commission on 8/21/01.
- I. A number of actions have been implemented to **decrease the nursing vacancy rate**, including:
1. Increasing recruitment efforts at nursing schools and conferences
 2. Providing training programs in all specialty areas
 3. Providing new graduate orientation programs, including Masters Entry into Practice of Nursing (MEPN) students
 4. Hiring Canadian nurses on TN Visas
 5. Processing nurses under H1B Visas with the assistance of Nancy Pelosi's office
 6. Streamlining the hiring process with the assistance of Human Resources

We are currently reviewing utilization data to determine our nursing resource needs for the winter. We will be challenged to staff our beds at a level that consistently runs 25-35 over our budgeted census for several reasons:

- Many of our current nurses work per diem to supplement our staffing. We may see an increase in the number of sick calls due to the anticipated shortage of flu vaccines again this year.
- The salary increases offered nurses in the Bay Area may eventually impact our ability to recruit and retain nursing staff.

I would like to acknowledge the work of the Bed Utilization Committee for their multidisciplinary approach to address barriers to patient flow. The Committee will begin to meet again in September to develop winter plans to meet bed demands.

2. **Diversion Summary Report**

See attached.

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 8/14/01

Sue Currin, RN, MS, Chief Nursing Officer

1. Summary of Activities Taken to Decrease Diversion at SFGH

SFGH submits a monthly Diversion Report to the Joint Conference Committee. The percent of diversion hours has steadily declined from 38% in 1/01 to 23% in 6/01. Over the last 9 months the Hospital has implemented a number of actions to decrease the diversion rate in our Emergency Department. I would like to take this opportunity to summarize our efforts to decrease diversion:

- A. The **Discharge Lounge (DL)** area was opened in 12/00. Patients discharged from an acute care unit may be taken to the DL while waiting for medications from the Pharmacy, rides home from friends/family members, delivery of DME, and hotel/shelter vouchers. Food, videos, and reading material are provided in the DL. Volunteers and nursing employees on Transitional Temporary Work Assignment (TTWA) staff the DL which is opened from 11:00 AM to 7:00PM, Monday through Friday.
- B. **Condition Yellow/Condition Red** was developed to provide guidelines for the management of severe bed shortages. Condition Yellow is instituted when ten or more patients are waiting for a bed. A multidisciplinary group of Nurse Managers, Charge Nurses, Pharmacy Supervisor, Environmental Services Supervisor, Social Services, Utilization Case Managers, and Chief Residents of Surgery, Medicine, and Family Practice are notified to facilitate immediate patient evaluations and discharge planning. Condition Red is considered an internal disaster activated when only one Critical Care bed is available with no pending transfers, the Post Anesthesia Recovery Room is at capacity impacting the OR schedule, and more than ten patients are waiting for beds. Condition Red necessitates the opening of the Command Post. In addition to those notified when a Condition Yellow is activated, the following respond during a Condition Red: CEO, Chief Nursing Officer, Chief of Staff, Service Chiefs, and Nursing Directors.
- C. The **4A SNF capacity was increased** from 20 to 30 by utilizing per diem RNs, registry CNAs, and overtime. Patients are screened for SNF placement by the Utilization Case Managers and discharge summaries are prepared in anticipation of bed availability. Admission hours for the SNF were extended from Monday through Friday 8:00 AM- 3:00 PM to 7 days/week, 24 hours per day.
- D. The **Chief Nursing Officer conducts patient rounds** Tuesdays and Thursdays with the Director of Nursing-Med-Surg, Director of Social Services, Nurse Manager-SNF and Director of Utilization Management. Decertified patients and those with complex

discharge plans are individually reviewed with the Nurse Manager, Charge Nurse, and Clinical Nurse Specialist on each unit. Patients going to the DL, SNF or to another level of care are discussed and prioritized. The group arranges for immediate follow up on identified issues to facilitate patient flow.

San Francisco General Hospital

Diversion Report

JULY 2001

Executive Summary

The Emergency Department [ED] recorded 47 episodes of diversion for 225 hours representing a rate of 30 % for July 2001. This is a 6% increase in diversion since June 2001.

The 47 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from previous month
Total diversion	41	209	28%	5% increase
Trauma over-ride	6	16	2%	1% increase

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 212 patients were awaiting admission to in-patient beds [ICU-23 4B/StepDown-79 MedSurg-110]. In July of 2000, the ED was on diversion 31% of the month. Trauma Override was invoked 2% of the month in July 2000.

Total diversion was recorded for 41 episodes, a total of 209 hours or a 28 % rate for July 2001.

Trauma override was recorded for 6 episodes, a total of 16 hours or a 2 % rate for July 2001. This is a 1% increase in trauma override from June 2001. While on Trauma override the ED held 31 patients awaiting inpatient beds.

Definitions:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSA definitions:

Total diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

- 1. The critical care bed capacity at SFGH is two or less beds.*
- 2. All SFGH internal diversion strategies have been exhausted*
- 3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.*

*Prepared by: Mary Jo Webb, RN, MSN
Director of Emergency Nursing*

San Francisco General Hospital
Emergency Department
2001
Total Diversion Summary

In July, the Emergency Department recorded 47 episodes of Total Diversion for 225 hours and 1 min, a percentage of 30.2 % for the month.

Date	Length	Summary of Event
07/01/01	1625-1910	31 patients in the ED Admits: 2-4B, 2-Floor ED waiting room: 4 urgent patients
07/01/01	2135-0235	25 patients in the ED Admits: 0 ED waiting room: 3
07/02/01	2300-0300	31 patients in the ED Admits: 2-4B, 1-Floor ED waiting room: 11 urgent patients
07/03/01	1100-1515	27 patients in the ED Admits: 2-4B, 8-Floor ED waiting room: 0
07/04/01	0105-0815	29 patients in the ED Admits: 4-Floor ED waiting room: 0
07/05/01	0130-0530	26 patients in the ED Admits: 2-4B ED waiting room: 0
07/05/01	1217-1515	27 patients in the ED Admits: 1-ICU, 1-4B ED waiting room: 0
07/05/01	2015-0100	32 patients in the ED Admits: 1-4B, 7-Floor ED waiting room: 9 urgent patients
07/06/01	1540-2100	33 patients in the ED Admits: 1-Floor ED waiting room: 1 urgent patient
07/06/01	2220-0009	27 patients in the ED Admits: 3-Floor ED waiting room: 10 urgent patients
07/07/01	0620-0830	28 patients in the ED Admits: 0 ED waiting room: 0
07/08/01	1605-2005	35 patients in the ED Admits: 2-ICU, 2-4B, 4-Floor ED waiting room: 4 urgent patients
07/08/01	2230-0015	26 patients in the ED Admits: 1-ICU, 3-4B, 2-Floor ED waiting room: 4 urgent patients
07/09/01	1352-0245	26 patients in the ED Admits: 1-ICU, 2-4B ED waiting room: 3 urgent patients
07/10/01	1317-2005	29 patients in the ED Admits: 1-ICU, 1-4B, 2-Floor ED waiting room: 6 urgent patients
07/11/01	1350-1825	31 patients in the ED Admits: 1-ICU, 1-4B, 3-Floor ED waiting room: 10 urgent patients

07/11/01	1930-0150	34 patients in the ED Admits: 3-4B, 4-Floor ED waiting room: 22 urgent patients
07/12/01	1800-2245	33 patients in the ED Admits: 2-4B, 7-Floor, 2-Direct Admits from clinics ED waiting room: 11 urgent patients
07/13/01	0055-0420	44 patients in the ED Admits: 1-4B, 8-Floor ED waiting room: 6 urgent patients
07/13/01	1310-1915	48 patients in the ED Admits: 1-4B, 7-Floor ED waiting room: 5 urgent patients
07/14/01	0040-0640	32 patients in the ED Admits: 1-Floor/ISOL ED waiting room: 10 urgent patients
07/15/01	1850-2115	28 patients in the ED Admits: 1-4B ED waiting room: 4 urgent patients
07/15/01	2330-0330	32 patients in the ED Admits: 1-ICU, 1-4B ED waiting room: 2 urgent patients
07/16/01	1305-0530	48 patients in the ED Admits: 1-ICU, 1-4B; Direct Admits: 4 ED waiting room: 11 urgent patients
07/17/01	1535-1705	35 patients in the ED Admits: 1-ICU, 1-4B ED waiting room: 5 urgent patients
07/18/01	1715-2110	32 patients in the ED Admits: 4-4B, 3-Floor ED waiting room: 9 urgent patients
07/19/01	1310-1815	30 patients in the ED Admits: 1-ICU, 4-4B, 7-Floor ED waiting room: 10 urgent patients
07/20/01	1700-1835	23 patients in the ED Admits: 1-ICU, 3-4B, 1-Floor ED waiting room: 8 urgent patients
07/20/01	2159-0117	42 patients in the ED Admits: 1-4E, 3-4B, 2-Floor ED waiting room: 25 urgent patients
07/21/01	0003-0630	39 patients in the ED Admits: 1-ICU, 5-Floor ED waiting room: 8 urgent patients
07/21/01	1300-1600	35 patients in the ED Admits: 1-ICU, 1-4B, 2-Floor ED waiting room: 9 urgent patients
07/21/01	1805-2005	27 patients in the ED Admits: 1-4B, 4-Floor ED waiting room: 6 urgent patients
07/22/01	2025-0225	33 patients in the ED Admits: 1-4B, 1-Floor ED waiting room: 5 urgent patients
07/23/01	1455-1822	40 patients in the ED Admits: 1-ICU ED waiting room: 0
07/24/01	2210-0426	30 patients in the ED Admits: 4-4B, 1-Floor ED waiting room: 6 urgent patients
07/25/01	1235-1415	50 patients in the ED Admits: 4-4B, 3-Floor ED waiting room: 0
07/25/01	1515-1655	36 patients in the ED Admits: 1-4B, 1-Floor ED waiting room: 5 urgent patients

07/25/01	1920-0420	28 patients in the ED Admits: 5-4B, 4-Floor ED waiting room: 14 urgent patients
07/26/01	1445-1800	52 patients in the ED Admits: 1-ICU, 2-4B, 2-Floor ED waiting room: 1 urgent patient
07/27/01	0004-0304	37 patients in the ED Admits: 2-4B ED waiting room: 12 urgent patients
07/27/01	1723-0040	43 patients in the ED Admits: 1-4B, 1-Floor ED waiting room: 6 urgent patients
07/28/01	0236-0328	38 patients in the ED Admits: 1-5E, 2-4B, 1-Floor ED waiting room: 1 urgent patient
07/28/01	0428-0630	36 patients in the ED Admits: 1-ICU, 3-4B, 2-Floor ED waiting room: 8 urgent patients
07/28/01	1840-2205	29 patients in the ED Admits: 1-ICU, 2-4B ED waiting room: 4 urgent patients
07/30/01	0010-0800	38 patients in the ED Admits: 1-ICU, 1-4B ED waiting room: 10 urgent patients
07/30/01	1722-2159	36 patients in the ED Admits: 3-4B ED waiting room: 16 urgent patients
07/31/01	1510-2300	38 patients in the ED Admits: 2-ICU, 2-4B ED waiting room: 10 urgent patients

San Francisco General Hospital
Emergency Department
2001
Trauma Override Summary

The Emergency Department recorded 6 episodes of Trauma Override for 16 hours and 15 min, a percentage of 2.2 % for the month of July.

Date	Length	Summary of Event
07/03/01	1445-1515	911-1, 912-6, 33 patients in the ED
07/06/01	1956-2018	911-1, 912-3, 36 patients in the ED
07/09/01	2130-0220	911-1, 36 patients in the ED
07/13/01	1650-1915	911-1, 912-7, 39 patients in the ED
07/16/01	1857-2015	911-1, 912-3, 32 patients in the ED
07/30/01	2230-0500	911-2, 912-2, 31 patients in the ED

**San Francisco General Hospital
Statement of Revenue and Expenses
Month ending July 31, 2001**

Overview:

Monthly Results:

Net Income, Page 1, Line 61, Column 3

Net Income for the month of June exceeds Budget by \$61,000. Patient service revenue continues to exceed budget, as was the case last year and is a result of continued high inpatient and outpatient volume, also in excess of budget. At the same time the cost of personnel services and fringe benefits exceed budget as staffing cost increases to manage additional patient volume. Additional Net Patient Revenue of \$162,000 (line 18) is therefore offset by Personnel Services and Fringe Benefit expenses of \$386,000 (lines 35 & 36).

The monthly financial statement also includes a one-time adjustment to record a \$362,000 recovery of prior year payments to outside consultants (line 28).

Gross Patient Revenue, Page 1, Line 8, Column 3

Gross patient revenue exceeded budget \$262,000 or 0.7%. This compares to a variance in average daily census of 4.3% (page 2, line 7).

Annual Projection:

Net Income, Page 1, Line 61, column 6

We are projecting a \$967,000 net loss for this fiscal year. This amount is based upon annualization of the continuing excess volume experienced last year and in July and August of this year, and the similar annualization of personnel expense variances discussed above. The projected net loss is basically a break even forecast in the context of a \$500,000,000 revenue budget.

Personnel Services, Page 1, Line 35, column 6

Projected expenses for the year are forecast to exceed budget by \$4,209,000 which largely is a result of additional staffing costs associated with additional inpatient volume.

Mandatory Fringe Benefits, Page 1, line 36, column 6

Projected Fringe Benefits for the year are also forecast to exceed budget.

Statistical indicators:

Patient Days Page 2, Lines 25, 30, and 31

Patient days, excluding MHRF exceed budget 4.3%. Including the MMRF, patient days exceed budget 2.9%. Adjusted Patient Days, which factor in outpatient activity, exceed budget by 2.1%. This is consistent with the patient day variances for all of 2000-2001 and is expected to continue.

FTEs per adjusted occupied bed, Page 2, Line 43, column 6

We do not have final data to update these statistics for July and have therefore reported budgeted data on lines 38-46.

Days Revenue in Accounts Receivable, Page 2, Line 61, column 6

The investment in accounts receivable increased from 84 days last month to 87 this month. This is largely due to some increase in Medical Record processing backlogs, although the backlogs are still within acceptable standards and significantly lower than levels seen in the prior year. We are setting a budget goal of 80 days for 2001-2002, which is aggressive, but believed to be achievable. We concluded 2000-2001 at 84 days however as of July 2000 our investment in AR was 125 days.

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/2002
Month Ending: JUL 31, 2001
(In Thousands of Dollars)

MONTHLY						ANNUAL					
		Fav/(Unfav)						Fav/(Unfav)			
Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual	
GROSS PATIENT REVENUE:											
12,923	14,710	(1,787)	-12.1%	13,187	Inpatient Medi-Cal Revenue	155,071	171,999	(16,928)	-9.8%	153,288	
3,956	4,820	(864)	-17.9%	3,734	Outpatient Medi-Cal Revenue	47,477	56,751	(9,274)	-16.3%	50,578	
4,970	5,159	(189)	-3.7%	5,613	Inpatient Medicare Revenue	59,635	60,321	(686)	-1.1%	63,264	
1,785	1,897	(112)	-5.9%	1,597	Outpatient Medicare Revenue	21,423	22,337	(914)	-4.1%	23,428	
11,251	8,864	2,387	26.9%	8,337	Inpatient Other Revenue	135,018	103,635	31,383	30.3%	117,606	
5,614	4,787	827	17.3%	4,988	Outpatient Other Revenue	67,365	56,365	11,000	19.5%	63,963	
40,499	40,237	262	0.7%	37,456	TOTAL PATIENT SERVICE REVENUE	485,989	471,408	14,581	3.1%	472,127	
REVENUE DEDUCTIONS:											
6,881	6,665	(216)	-3.2%	4,491	Charity Care	82,574	76,680	(5,894)	-7.7%	80,219	
13,354	14,956	1,602	10.7%	13,616	Provision for Medi-Cal Adjustments	160,248	175,229	14,981	8.5%	161,290	
3,352	2,538	(814)	-32.1%	2,589	Provision for Medicare Adjustments	40,224	29,737	(10,487)	-35.3%	43,021	
5,072	4,017	(1,055)	-26.3%	4,842	Provision for Other Adjustments	60,859	48,463	(12,396)	-25.6%	54,599	
1,708	2,091	383	18.3%	1,917	Provision for Bad Debt	20,500	24,500	4,000	16.3%	19,022	
30,367	30,267	(100)	-0.3%	27,455	TOTAL REVENUE DEDUCTIONS	364,405	354,609	(9,796)	-2.8%	358,151	
10,132	9,970	162	1.6%	10,001	NET PATIENT SERVICE REVENUE	121,584	116,799	4,785	4.1%	113,976	
OTHER OPERATING REVENUE:											
710	710	0	n/a	663	Capitation/Managed Care Settlement	8,519	8,519	0	n/a	9,537	
421	421	0	n/a	308	Short Doyle	5,054	5,054	0	n/a	4,654	
0	0	0	n/a	0	MHRF Funding	0	0	0	n/a	0	
10,515	10,515	0	n/a	10,626	SB855	126,183	126,183	0	n/a	104,112	
1,808	1,808	0	n/a	1,808	SB1255	21,700	21,700	0	n/a	22,000	
108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300	
594	660	(66)	-10.0%	0	Revenue form Other City Departments	7,132	7,924	(792)	-10.0%	9,394	
362	0	362	n/a	4	Prior Year Settlement	362	0	362	n/a	(3,679)	
333	333	0	n/a	292	MAA & Other Net Patient Revenue	4,000	4,000	0	n/a	4,085	
14,851	14,555	296	2.0%	13,809	TOTAL OTHER OPERATING REVENUE	174,250	174,680	(430)	-0.2%	151,403	
24,983	24,525	458	1.9%	23,810	TOTAL OPERATING REVENUE	295,834	291,479	4,355	1.5%	265,379	
OPERATING EXPENSES:											
13,894	13,582	(312)	-2.3%	12,236	Personnel Services	167,195	162,986	(4,209)	-2.6%	154,275	
3,331	3,257	(74)	-2.3%	2,942	Mandatory Fringe Benefits	40,088	39,079	(1,009)	-2.6%	37,027	
7,716	7,716	0	n/a	7,724	Contractual Services	92,592	92,592	0	n/a	96,497	
2,022	2,022	0	n/a	2,087	Materials and Supplies (excl. Pharm.)	24,270	24,270	0	n/a	26,664	
1,167	1,167	0	n/a	1,220	Pharmaceuticals	14,000	14,000	0	n/a	12,710	
393	393	0	n/a	305	Facilities Maintenance & Capital Outlay	4,719	4,719	0	n/a	5,906	
1,399	1,399	0	n/a	1,211	Services of Other Departments	16,790	16,790	0	n/a	16,021	
(78)	(87)	(9)	-10.3%	(910)	Expenditure Recovery	(937)	(1,041)	(104)	-10.0%	(639)	
8,185	8,185	0	n/a	8,185	Operating Transfer Out	98,225	98,225	0	n/a	67,996	
427	427	0	n/a	187	Intrafund Transfer	5,129	5,129	0	n/a	2,248	
0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0	
436	436	0	n/a	336	Continuing Projects	5,230	5,230	0	n/a	5,131	
38,892	38,497	(395)	-1.0%	35,523	TOTAL OPERATING EXPENSES	467,301	461,979	(5,322)	-1.2%	423,836	
(13,909)	(13,972)	63	0.5%	(11,713)	OPERATING INCOME/(LOSS)	(171,467)	(170,500)	(967)	-0.6%	(158,457)	
NON-OPERATING REVENUE:											
8,020	8,020	0	n/a	6,318	General Fund	96,245	96,245	0	n/a	81,090	
5,093	5,093	0	n/a	5,093	Realignment	61,113	61,113	0	n/a	61,113	
285	285	0	n/a	312	Prop 99	3,423	3,423	0	n/a	3,807	
537	537	0	n/a	517	Transfer In and Project-Related	6,442	6,442	0	n/a	2,723	
0	0	0	n/a	131	Carryforward	0	0	0	n/a	10,074	
73	75	(2)	-2.7%	73	Cafeteria	877	877	0	n/a	758	
200	200	0	n/a	214	Miscellaneous	2,400	2,400	0	n/a	2,439	
14,208	14,210	(2)	0.0%	12,658	TOTAL NON-OPERATING REVENUE	170,500	170,500	0	n/a	162,004	
299	238	61	25.6%	945	NET INCOME/(LOSS)	(967)	0	(967)	n/a	3,547	

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/2002
Month Ending: JUL 31, 2001

CURRENT MONTH						YEAR-TO-DATE					
Actual	Budget	Variance	% Var	Prior Year		Actual	Budget	Variance	% Var	Prior Year	
KEY VOLUME INDICATORS											
<u>Discharges (incl. MHRF)</u>											
1,292	1,459	(167)	-11.4%	1,539	Discharges (incl. MHRF)	1,292	1,459	(167)	-11.4%	1,539	
1,795	2,043	(248)	-12.1%	2,124	Adjusted Discharges (incl. MHRF)	1,795	2,043	(248)	-12.1%	2,124	
<u>Average Daily Census</u>											
187	182	5	2.9%	193	Acute Med/Surg ADC	187	182	5	2.9%	193	
93	92	1	1.5%	103	Psych ADC	93	92	1	1.5%	103	
25	19	6	31.6%	20	Skilled Nursing ADC	25	19	6	31.6%	20	
306	293	13	4.3%	316	Total ADC excl. MHRF	306	293	13	4.3%	316	
140	140	(0)	-0.3%	132	MHRF ADC	140	140	(0)	-0.3%	132	
445	433	12	2.8%	448	Total Adult ADC	445	433	12	2.8%	448	
7	7	(0)	-1.4%	7	Nursery ADC	7	7	0	n/a	7	
7.5	6.4	(1.1)	-17.2%	6.4	Average Length of Stay (excl. MHRF)	7.5	5.6	(1.9)	-33.9%	6.4	
1,295	1,295	-	n/a	1,506	<u>Medicare Case Mix Index</u>	1,295	1,295	-	n/a	1,506	
<u>Payor Mix (Gross Revenue)</u>											
41.7%	48.5%	-6.8%	-14.1%	45.2%	Medi-Cal	41.7%	48.5%	-6.8%	-14.1%	45.2%	
16.7%	17.5%	-0.8%	-4.7%	19.3%	Medicare	16.7%	17.5%	-0.8%	-4.7%	19.3%	
41.6%	34.0%	7.6%	22.5%	35.6%	Other	41.6%	34.0%	7.6%	22.5%	35.6%	
100.0%	100.0%	0.0%	n/a	100.0%	Total	100.0%	100.0%	0.0%	n/a	100.0%	
<u>Patient Days</u>											
5,172	4,760	412	8.7%	5,538	Medi-Cal Patient Days (excl. MHRF)	5,172	4,760	412	8.7%	5,538	
2,069	2,052	17	0.8%	2,307	Medicare Patient Days (excl. MHRF)	2,069	2,052	17	0.8%	2,307	
2,236	2,271	(35)	-1.5%	1,948	Other Patient Days (excl. MHRF)	2,236	2,271	(35)	-1.5%	1,948	
9,477	9,083	394	4.3%	9,793	Total Patient Days(excl. MHRF)	9,477	9,083	394	4.3%	9,793	
5,445	5,336	109	2.0%	6,198	Medi-Cal Patient Days	5,445	5,336	109	2.0%	6,198	
2,069	2,092	(23)	-1.1%	2,308	Medicare Patient Days	2,069	2,092	(23)	-1.1%	2,308	
6,292	5,995	297	5.0%	5,375	Other Patient Days	6,292	5,995	297	5.0%	5,375	
13,806	13,423	383	2.9%	13,881	Total Patient Days	13,806	13,423	383	2.9%	13,881	
19,185	18,798	387	2.1%	19,159	Adjusted Patient Days	19,185	18,798	387	2.1%	19,159	
82.9%	80.6%	2.3%	2.9%	83.4%	<u>% Occupancy (available beds)</u>	82.9%	80.6%	2.3%	2.9%	83.4%	
KEY OPERATIONAL INDICATORS											
<u>Labor</u>											
2,296	2,296	0	n/a	2,287	FTEs - Productive	2,296	2,296	0	n/a	2,287	
313	313	0	n/a	333	FTEs - Non-Productive	313	313	0	n/a	333	
2,609	2,609	0	n/a	2,620	Total FTEs - SFGH Only	2,609	2,609	0	n/a	2,620	
334	334	0	n/a	334	UC Non-Academic FTEs	334	334	0	n/a	334	
2,943	2,943	0	n/a	2,954	Grand Total FTEs Incl. UC	2,943	2,943	0	n/a	2,954	
4.8	4.9	0.1	2.0%	4.8	FTEs Per AOB (incl. UC)	4.8	4.9	0.1	2.0%	4.8	
\$ 59,353	\$ 59,353	\$0	n/a	\$58,568	Average Labor Cost per SFGH FTE	\$ 59,353	\$59,353	\$0	n/a	\$ 58,568	
24.0%	24.0%	0.0%	n/a	24.0%	Fringe Benefits as % of Salary	24.0%	24.0%	0.0%	n/a	24.0%	
227	227	0	n/a	332	Vacancy positions (as of the last PPE)	227	227	0	n/a	332	
<u>Revenues</u>											
\$ 1,302	\$ 1,305	(\$3)	-0.2%	\$1,280	Oper. Rev. Per Adjusted Patient Day (incl. MHRF)	\$ 1,302	\$1,305	(\$3)	-0.2%	\$1,280	
\$ 654	\$ 643	\$11	1.7%	\$625	Oper. Rev. (excl. SB855/1255/GME)/APD	\$ 654	\$643	\$11	1.7%	\$625	
\$ 13,919	\$ 12,005	\$1,914	15.9%	\$11,542	Oper. Rev. Per Adjusted Discharge	\$ 13,919	\$12,005	\$1,914	15.9%	\$11,542	
\$ 6,993	\$ 5,920	\$1,073	18.1%	\$5,637	Oper. Rev. (excl. SB855/1255/GME)/Adj. Discharge	\$ 6,993	\$5,920	\$1,073	18.1%	\$5,637	
<u>Expenses</u>											
\$ 2,027	\$ 2,056	\$29	1.4%	\$1,854	Operating Exp. Per Adjusted Pt. Day	\$ 2,027	\$2,056	\$29	1.4%	\$1,854	
\$ 1,601	\$ 1,621	\$20	1.2%	\$1,427	Operating Exp.(excl. IGT)/Adj. Pt. Day	\$ 1,601	\$1,621	\$20	1.2%	\$1,427	
\$ 21,668	\$ 18,917	(\$2,751)	-14.5%	\$16,725	Operating Exp. Per Adj. Discharge	\$ 21,668	\$18,917	(\$2,751)	-14.5%	\$16,725	
\$ 17,108	\$ 14,911	(\$2,197)	-14.7%	\$12,871	Operating Exp.(excl. IGT)/Adj. Discharge	\$ 17,108	\$14,911	(\$2,197)	-14.7%	\$12,871	
31.5%	32.6%	1.1%	3.4%	33.1%	Supply Expense as % of Net Pt. Revenue	31.5%	32.6%	1.1%	3.4%	33.1%	
87	80	(7)	-8.8%	125	<u>Days Revenue in Accounts Receivable*</u>	87	80	(7)	-8.8%	125	

Executive Statement
Joint Conference Committee- SFGH
Integrated Soft Tissue Infection Services (ISIS) Clinic

Background

The ISIS Clinic represents the coordinated response of several Departments within the SFGHMC to the treatment of patients with soft tissue infections. Prior to July 2000 patients with significant soft tissue infections (principally abscesses and cellulitis) were treated as outpatients in the ED or admitted to the hospital. Consequently, care for this specific patient population resulted in approximately 3000 ED visits, 2400 admissions (7200 bed-days), and 1000 cases in the OR each year. Annual costs to the hospital were *estimated* to range from 8 to 10 million dollars. In addition, there was a growing consensus that these necessary services could be administered in a manner that was more efficient and effective.

Goals

The basic goal of the clinic was to create a user-friendly, non-judgemental environment for the compassionate, efficient and cost-effective care of patients with soft tissue infections.

Specifically,

- 1) All patients are to have access to/receive substance abuse counseling, social service support, and the opportunity to enter the methadone program on request.
- 2) Provide access to rehabilitation therapy and nutritional evaluation as needed;
- 3) To develop treatment protocols based on the experiences of present outpatient treatment centers and our experience at SFGH.
- 4) The monthly review of patient outcomes including failure rate of treatments, recidivism rates, and patients lost to follow-up. The treatment failure rate should be low enough to justify the treatment algorithms.

The patients are referred from anywhere within the City health care system and receive timely, humane and non-judgmental care for their soft tissue infections. We projected that 90% of the patients that were receiving acute inpatient care on a Surgical Service could be properly cared for as an outpatient via this clinic. Patients with severe, life-threatening or necrotizing infections would remain on the traditional Surgical Services. In addition, the ISIS Clinic would provide patients with the necessary educational and detoxification facilities to give the user of injection drugs an opportunity to interrupt the cycle of continued drug abuse and future soft tissue infections through education, directed methadone therapy, and social service intervention for this at-risk population.

Utilization Data

Table 1. ISIS Clinic patient volume for FY 2000-01.

patient visits	new patients	F/U visits	admissions	lost to F/U	treatment failures
3365	2861	504	190	14%	68 (2%)

Table 2. ISIS Clinic Patients Payer Mix for FY 2000-01 (N = 300).

General Assistance	MediCal	Self-Pay	Medicare	Jail	Private Insurance	Bad Debt	Worker's Compensation
53%	19%	14%	7%	5%	1%	1%	<1%

Table 3. ISIS Clinic procedures for FY 2000-01.

All Procedures	I & D	debridements	hand infections	perianals, pilonidals	necrotizing fasciitis	cellulitis
2114	1722	211	232	83	7	943

Table 4. ISIS Clinic Patient Population.

Description	Total	Percent (%)
Gender		
male	1321	70
female	571	30
Age (mean)	40 ± 5 years	--
Ethnicity		
white	794	43
African-American	608	33
Hispanic	340	18
Asian	106	6
Native American	10	<1
Viral Serologies (positives)		
hepatitis B	186	12
hepatitis C	573	37
HIV	143	9
AIDS	60	4
Residence (n = 1854)		
private home/hotel	1148	64
homeless	530	30
County Jail	42	2
shelter	37	2
rehabilitation program	23	1
Source of Referral (n = 3205)		
SFGH Emergency Department	1025	32
CHN Clinics	518	16
SFGH inpatient wards	449	14
Walk-in (self-referrals)	957	30
Outside clinics/hospitals	141	4
County Jail	115	4
Drug Use (N = 1729)		
Not using (clean)	676	39
heroin (black tar)	681	39
crack/cocaine	85	5
metamphetamines	85	5
marijuana	68	4
polysubstance users	134	8
Methadone Treatment (n = 1493)		
not receiving treatment	1109	74
methadone maintenance or detoxification	343	23
refused SACS referral	41	3

Three hundred (310) and ten patients have been enrolled in a 21-day methadone detoxification program with an average participation time of 17.2 days. An additional 33 patients have been referred from the ISIS Clinic and currently participate in a methadone maintenance program with a >90% retention rate. ISIS Clinic recidivism rates are relatively low with 83% of patients presenting with a single diagnosis (infection) during FY 2000-01. Less than 7% of patients presented with three or more distinct diagnosis during the same time period.

Conclusions

The ISIS Clinic has been more successful than planned serving a volume of patients that exceeds *twice* the original estimate. Consequently, the Clinic needs

- 1) additional renovated space on Ward 4C as previously designated;
- 2) additional nursing staff to be trained, hired and assigned to work in the Clinic;
- 3) adequate funding to support the ISIS Clinic activities.

The ISIS Clinic Co-Directors and Head Nurse have engaged in discussions regarding the further expansion of services to possibly include minor surgical procedures and an inpatient unit, each of which would likely further improve the quality of service rendered and reduce hospital costs.

Integrated Soft Tissue Infection Services

San Francisco General Hospital,
San Francisco Community Health Network

Presentation to the
Joint Conference Committee-SFGH
August 14, 2001

ISIS Clinic Goal

The basic goal of the Integrated Soft Tissue Infection Services (ISIS) Clinic is to provide compassionate, efficient and cost-effective care to patients with soft tissue infections in a user-friendly, non-judgmental environment.

ISIS Clinic

Clinic Staff:

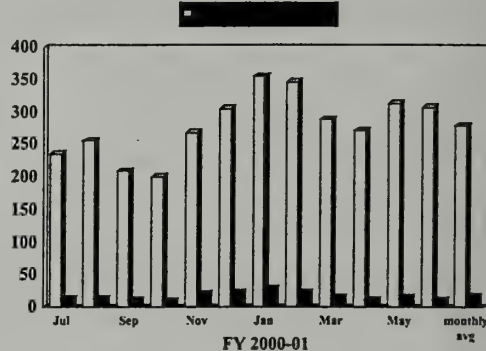
- Attending Surgeons
- SFGH Nurses
- SACS Counselors
- Social Workers
- Pain Management Specialists
- Rehabilitation Therapists
- Ancillary Services
- (Wound Care Nurses)

Clinic Location: SFGH Ward 4C

Hours: Mon-Fri 8 am to 4 pm;

Sat/Sun/holidays 8 am to 12 noon

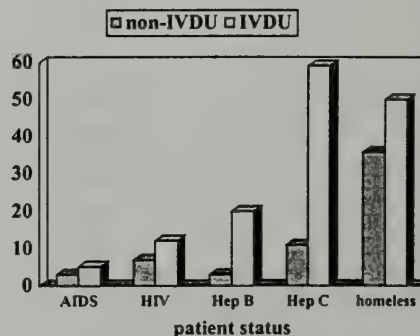
ISIS Clinic Volume



ISIS Patient Demographics

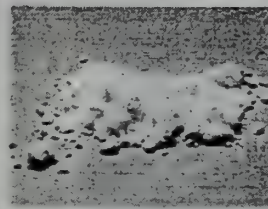
	Total	Percent (%)
GENDER		
men	1321	70
women	571	30
AGE (years, mean \pm sd)	40 \pm 5	
ETHNICITY		
white	794	43
African-American	608	33
Hispanic	340	18
Asian	106	6
Native American	10	<1
VIRAL SEROLOGIES (positive)		
Hepatitis C	573	37
Hepatitis B	186	12
HIV	143	9
AIDS	60	4

ISIS Patient Demographics



ISIS Patient Demographics

	Total	Percent (%)
DRUG USE		
actively	1053	61
none/currently clean	676	39
DRUG of CHOICE		
heroin (black tar)	681	65
cocaine/crack	85	8
amphetamines	85	8
marijuana	68	6
polysubstance users	134	13
METHADONE TREATMENT		
Receiving treatment	343	23
Not receiving treatment	1109	74
Refused referral	41	3



"China White"

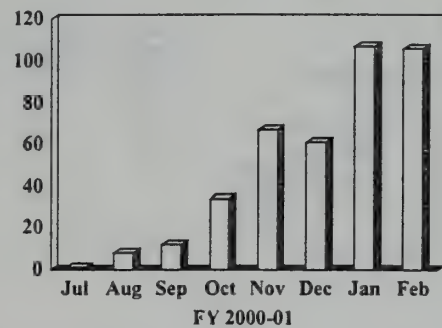


"Black Tar"

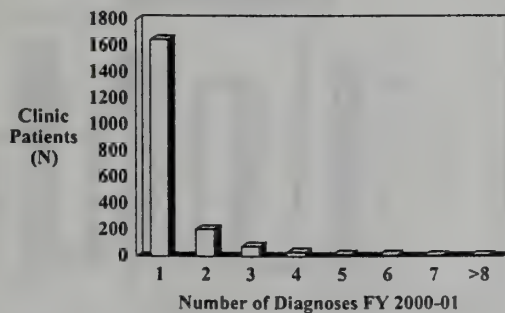
ISIS Patient Demographics

	Total	Percent (%)
RESIDENCE		
home (apt., hotel, friend's)	1148	64
homeless (street)	530	30
County Jail	42	2
shelter	37	2
rehabilitation program	23	1
REFERRAL SOURCES		
Emergency Department	1025	33
Walk-in (self referrals)	843	27
CHN Clinics	518	17
Inpatient wards	449	15
Outside clinics/hospitals	141	5
County Jail	115	4

ISIS Clinic Volume



ISIS Clinic Recidivism



Abscess



Cellulitis



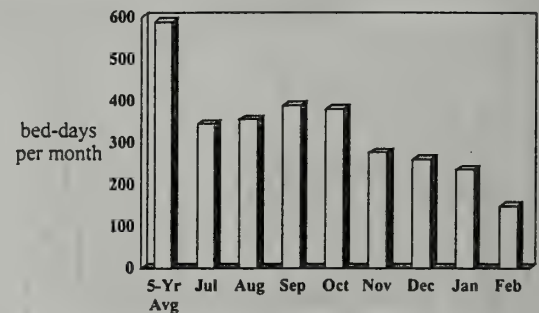
Wound Debridement



ISIS Clinic Volume

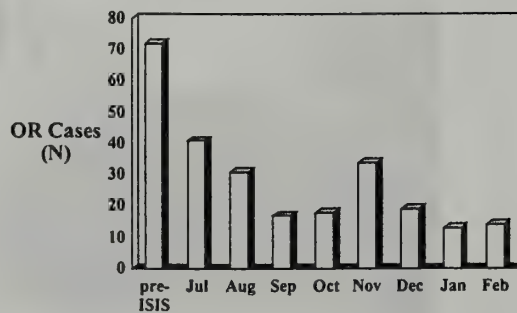
	Totals (FY 2000-01)	Monthly Avgs
PROCEDURES	2114	176
I & D	1722	144
hand infection	232	19
debridement	211	18
perianals/pilonidals	83	7
necrotizing fasciitis	7	<1
CELLULITIS	943	79

Impact of ISIS on Hospital Admissions



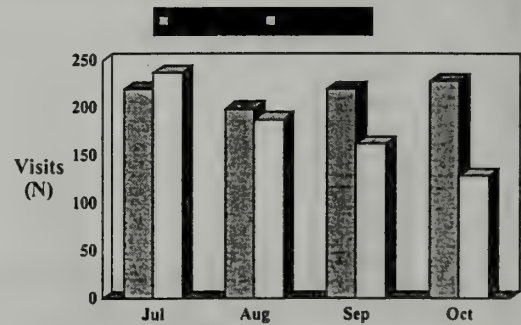
FY 2000-01

Impact of ISIS on OR Volume

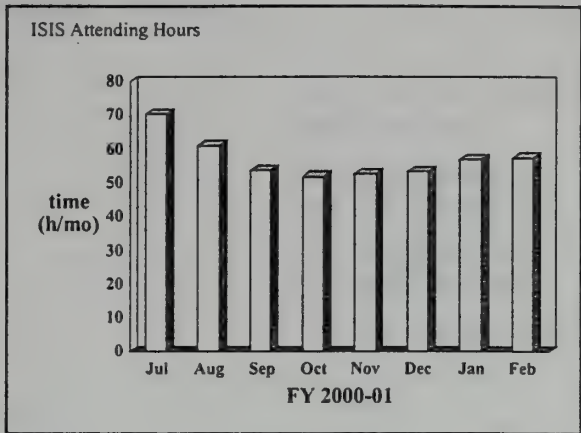
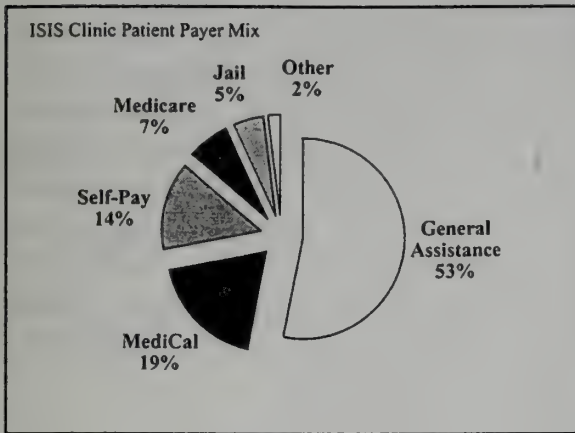


FY 2000-01

Impact of ISIS on ED Visits



FY 2000-01



City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

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1/01
2
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Vice President

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Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

Tel. (415) 554-2666
FAX (415) 554-2665

Web Site: <http://www.dph.sf.ca.us>

AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, September 11, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

DOCUMENTS DEPT.

SEP 13 2001

SAN FRANCISCO
PUBLIC LIBRARY

- 1) CALL TO ORDER
- 2) CLOSED SESSION

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: APPROVAL OF CLOSED SESSION MINUTES
OF AUGUST 14, 2001

**FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT,
QUALITY OF CARE, QUALITY ASSURANCE
AND CREDENTIALING MATTERS**

J. Renee Navarro, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

D) Reconvene in Open Session

1. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(a).)

3) PUBLIC COMMENT*

4) ADJOURNMENT

- * Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines *#9 San Bruno*, *#9X San Bruno Express*, *#19 Polk* (stops 2 blocks away), *#33 Haight Ashbury*, and *#48 Quintara*. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web site at: **www.ci.sf.ca.us/bdsupvrs/sunshine**

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, October 9, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF AUGUST 14, 2001
**Minutes of August 14, 2001*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
**Report*
- 5) FOR DISCUSSION: ADMINISTRATIVE MEDICAL STAFF REPORT
(J. Renee Navarro, M.D., Chief of Staff)
**Report*

6) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
**Report*

7) FOR ACTION: APPROVAL OF GOVERNING BODY BYLAWS
(Kathleen Murphy, Deputy City Attorney, SFGH)
**Report*

8) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

B) Vote on Whether to Hold a Closed Session

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: APPROVAL OF CLOSED SESSION MINUTES OF AUGUST 14, 2001

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE AND CREDENTIALING MATTERS

J. Renee Navarro, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)

2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

8) ADJOURNMENT

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

* Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines *#9 San Bruno*, *#9X San Bruno Express*, *#19 Polk* (stops 2 blocks away), *#33 Haight Ashbury*, and *#48 Quintara*. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine

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CITY AND COUNTY OF SAN FRANCISCO

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Director of Health

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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, October 9, 2001
3:45 p.m.

1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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1) CALL TO ORDER

The meeting of the San Francisco General Hospital Joint Conference Committee was called to order by Commissioner John I. Umekubo, M.D. at 3:50 p.m.

Present: Commissioner John I. Umekubo, M.D.
Absent: Commissioner Lee Ann Monfredini, Chair

Staff: Sue Currin, Philip Hopewell, M.D., John Kanaley, John Luce, M.D., Alison Moed, Kathleen Murphy, J. Renee Navarro, M.D., Gregg Sass, Hiro Tokubo, Chris Wachsmuth, Connie Young, Monique Zmuda

2) APPROVAL OF MINUTES OF AUGUST 14, 2001

Action Taken: The Committee approved the minutes of the August 14, 2001 Joint Conference Committee Meeting.

3) HOSPITAL HEALTHCARE UPDATE

(Activities and operations of SFGH)

(Sue Currin, R.N., Chief Nursing Officer, San Francisco General Hospital Medical Center)

Sue Currin presented the Hospital Healthcare Update.

AVON PRODUCTS FOUNDATION AWARD RECIPIENT

Ms. Currin announced that San Francisco General Hospital Medical Center, in conjunction with UCSF Mt. Zion, is the recipient of a \$10 million grant from the Avon Products Foundation. The money will be spent in pursuit of three primary goals: to include more women of color in research; to provide equal access to the best breast care for medically-underserved women; and to develop new methods of educating providers and the public in all aspects of breast care and treatment. Out of the \$10 million awarded, SFGH will receive \$6 million to provide direct breast care services and educational services to our clients, including the expansion of mammography and building of a Women's Imaging Center on Campus by 2002. The remaining \$4 million will be disbursed to UCSF Mt. Zion's Comprehensive Cancer Center to conduct research into causes and potential cures for breast cancer.

Gene O'Connell is currently in New York City to officially receive the grant from the Avon Foundation on behalf of SFGH.

SFGH FOUNDATION RETREAT

The San Francisco General Hospital Foundation held their annual retreat on September 19, 2001. The focus on the retreat was to identify issues important to the continued growth and success of the Foundation. Issues identified fell into three general categories of Mission, Growth, and Outreach. Through the facilitation of Dr. Grossman and Bob Glavin and the organizational leadership skills of Susan Jacobson, Executive Director of the SFGH Foundation, the board members collaboratively developed the following recommendations:

- ◆ Mission
To improve the care and comfort of the patients served by San Francisco General Hospital
- ◆ Growth
Work to increase annual income to \$5,000,000 to enable funding of initiatives, operations, and contributions to Endowment
- ◆ Outreach
Heighten the image of SFGH in the community

In meeting these recommendations, all members will be focusing on the following upcoming SFGH Foundation activities:

- ◆ Increasing awareness around the annual giving campaign by performing more outreach and public relations
- ◆ Working with the Combined Charities Campaign to promote the 1001 Club
- ◆ Posting of the SFGH Foundation Annual Report on the web
- ◆ Create and undertake an outreach plan for women's health and trauma center
- ◆ Address current public concern with disaster preparedness by building public awareness of and support SFGH status as a Trauma Center
- ◆ Integrate ideas generated by members during the retreat into work committees and Board

- ◆ Board members to encourage other board members not in attendance to participate in next steps

Ms. Currin thanked Susan Jacobson and Dr. Grossman for their leadership in creating an overwhelmingly successful retreat. She also thanked Commissioner David Sanchez and Dr. Philip Hopewell, UCSF Associate Dean for SFGH, for attending and contributing to the retreat's success.

SFGH's RESPONSE TO THE SEPTEMBER 11th INCIDENT

In response to the events in both New York City and Washington DC, San Francisco General Hospital activated the Hospital Emergency Incident Command System (HEICS) on September 11th at 0750 a.m. Gene O'Connell assumed the role of Incident Commander. The immediate concern was to assess the hospital's readiness to respond in case of a disaster.

Initial efforts were aimed at notifying the Campus of the HEICS activation as well as assessing the current hospital status. Status information that was requested included: Campus census and the availability of labor pool, blood, materials and supplies, and housing in case staff were needed to stay at the hospital. Staff was immediately notified using the overhead paging system and a departmental telephone notification system initiated through the nursing office. Key roles in HEICS were activated and additional positions, such as the Staff Support Unit Leader, were activated later in the day in response to anticipated needs.

A major concern was the safety and security of the Campus and control of the hospital perimeter. Security Chief Sgt. Restauro directed Institutional Police to immediately initiate the following measures:

- Halt all parking on the main hospital driveway
- Restrict access to the ambulance drive entrance to emergency vehicles only
- Verify identification and restrict access to the loading dock on Vermont Street
- Control entrance and egress from the main lobby and clinic entrances through the following:
 - Ensuring staff photo identification badges are worn by all personnel
 - Verifying appointments for all out patients presenting to hospital
 - Verifying names of patients for incoming visitors
 - Verifying appointments / meetings with visitors

San Francisco Police Department Mission Station Sergeant in Charge also visited SFGH in order to review security capabilities and determine areas of weakness. Evacuation policies were reviewed and the need for support in this scenario was discussed. Current capabilities and status was discussed. A copy of the SFGH Emergency Response Plan as well as key contact names and numbers was given to the SFPD.

The Command post remained active until 0900 hours Wednesday, September 12th. Prior to the deactivation, a command post briefing was held at 0730 hours to review the hospital and City's status. Due to the overwhelming positive response from staff, it was decided at that time to keep hospital and Campus security measures in place until further notice. In reviewing the status, it was also determined that since the onset of these security measures, reports to the Institutional Police for thefts, physical and/or verbal abuse had dropped to zero.

JCAHO MOCK SURVEY

During the week of September 10th, Steven Hirsch and Associates conducted a JCAHO mock survey at San Francisco General Hospital Medical Center. Throughout the survey, all of the mock surveyors complimented all of the SFGHMC staff on their sincerity, courtesy and forthcoming nature in responding to all of their questions. Despite what was occurring throughout the nation, the staff remained strong and dedicated to the mock survey and continued to participate.

At the conclusion of the survey, each of the mock surveyors presented an overview of their preliminary findings during an open staff meeting at Carr Auditorium. Over a hundred staff attended this closing conference and in addition, we were also honored to have Commissioner Chow at SFGH for the briefing.

Both Commissioners Monfredini and Umekubo have been briefed on the preliminary findings and once the official report is received from Steven Hirsch and Associates, it will be presented to the JCC-SFGH.

AB 430 DIRECTOR'S ADVISORY COMMITTEE

Gene O'Connell has been appointed to the Statewide Assembly Bill 430 (AB 430) Director's Advisory Committee to represent Northern California. This committee is chaired by Richard Watson, Interim Director of the State Emergency Medical Services Authority and will be overseeing the implementation of AB 430 with a particular focus on the disbursement of AB 430 funding. AB 430 (Cardenas et al) was passed by the Legislature and signed into law by Governor Davis on August 9, 2001. Section 50.5 of this bill provides for one-time funding for preparation and implementation of trauma care system plans for local emergency medical services (EMS) agencies that currently do not have an approved trauma plan. There are 13 EMS agencies currently without an approved trauma plan that may qualify for funding under this bill. The amount of each agency's one-time award will be based on clearly measurable objectives, justified need, and availability of funds. Funds disbursed under this program must be used to support activities related to the preparation and implementation of a trauma care system plan for local EMS agencies that do not currently have an approved trauma plan.

SFGH SENDS SUPPORT TO BELLEVUE HOSPITAL

Gene O'Connell called an emergency management forum the week following the September 11th incident to be able to "regroup" with all department managers and provide them inspirational support and self-care tips. Reverend Bob Walters attended and provided words of support and Dr. Okin, Dr. Alicia Boccellari, and Dr. Miriam Martinez from the Department of Psychiatry provided tips on to take care of themselves and loved ones in coping with the act of terrorism.

During the meeting, Susan Gearhart, Director of the Department of Education and Training, suggested that a card be sent to Bellevue, our sister hospital in New York City, providing them words of support and thoughts. Management forum supported the effort and the result was a beautiful 10-foot banner with a picture of SFGH and of the City. The banner was made available in the hospital's 2nd floor main hallway for all staff to sign. The banner was sent out last week to Bellevue with the entire banner covered with signatures and thoughts from SFGH staff to Bellevue's staff. Bellevue received the banner and has thanked SFGH for all of their well wishes.

Special thanks to Susan Gearhart for the wonderful idea and coordinating the effort as well as Sharon Calcagno, Director of SFGH Information Systems, and her staff, for creating the beautiful banner, and Gloria Rodriguez for assisting Susan Gearhart in the coordination.

Commissioners' Comments

- Commissioner Umekubo asked if there was any way to communicate to the public that the new security measures will not result in any one being denied care. Sue Currin responded that they could post signs in the two lobbies, in various languages, stating that access will not be denied. John Kanaley added that another suggestion being considered is having the guards that are posted at the entrances dressed in regular clothes, rather than full uniform. Commissioner Umekubo stated that it is necessary to insure the safety of staff and patients.

4) **PATIENT CARE REPORT**
(Sue Currin, RN, Chief Nursing Office)

Sue Currin presented the Patient Care Report (Attachment A).

5) **MEDICAL STAFF REPORT**
(J. Renee Navarro, M.D., Chief of Staff)

Dr. Renee Navarro presented the Medical Staff Report (Attachment B).

6) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**
(Gregg Sass, CHN Chief Financial Officer)

Gregg Sass presented the Statement of Revenues and Expenses for August 2001 and September 2001 (Attachment C).

Commissioners' Comments

- Commissioner Umekubo asked what impact the decline in local revenues such as hotel tax and sales tax would have on the Department's budget. Monique Zmuda responded that the Mayor's Office has asked all departments to develop a plan for current year budget reductions. The City has imposed a citywide freeze on hiring. Ms. Zmuda has requested a waiver from the freeze for both San Francisco General Hospital and Laguna Honda Hospital. She plans to present a plan for meeting the Mayor's directive to the Health Commission in November.

7) **APPROVAL OF GOVERNING BODY BYLAWS**
(Kathleen Murphy, Deputy City Attorney, SFGH)

Kathleen Murphy presented the proposed amendments to the Governing Body Bylaws. The amendments reflect changes in practices, such as the elimination of the reporting relationship to the CHN Executive Administrator and the impact of the Sunshine Ordinance on the Joint Conference Committee. The changes also reflect updates in JCAHO language emphasis. Ms. Murphy stated that the Bylaws will be submitted to the full Health Commission for approval.

Action Taken: The Committee approved the proposed Governing Body Bylaws.

8) **CLOSED SESSION**

A) **Public Comments on All Matters Pertaining to the Closed Session**

None.

B) **Vote on Whether to Hold a Closed Session**

Action Taken: The Committee voted to go in to Closed Session.

The Committee went into Closed Session at 4:45 p.m.

Individuals present in the Closed Session were the same as those present in the Open Session.

C) **Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1**

APPROVAL OF CLOSED SESSION MINUTES OF AUGUST 14, 2001

Action Taken: The Committee approved the Closed Session Minutes of August 14, 2001.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE AND CREDENTIALING MATTERS

J. Renee Navarro, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

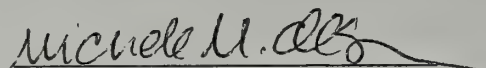
The Committee came out of Closed Session at 5:35 p.m.

D) **Reconvene in Open Session**

Action Taken: The Committee voted not to disclose any discussions held in Closed Session (San Francisco Administrative Code Section 67.12(a)).

8) **ADJOURNMENT**

The meeting was adjourned at 5:35 p.m.



Michele M. Olson
Health Commission Secretary

Attachments (3)

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 10/9/01

Sue Currin, RN, MS, Chief Nursing Officer

1. Bed Utilization Committee

The Bed Utilization Committee will reconvene in October to finalize a winter plan. The Committee will review Condition Red/Yellow data and the strategies implemented the first quarter of 2001. A major focus will be the development a Condition Red/Yellow policy and procedure for the perinatal services. During the months of August and September the census reached the highest census level experienced since the renovation of 6C and 6H were completed. In addition, OR scheduling procedures will be reviewed and actions inserted into Condition Red/Yellow based on the number of come and stay surgeries planned.

2. Procedure for Reporting RN, LVN, LPT, CNA Staff to the State of California

A policy and procedure was developed and approved by the Nursing Executive Committee to address allegations of staff behavior that is potentially reportable to the State of California. The policy ensures that the Chief Nursing Officer is informed of allegations, any steps taken or contemplated to ensure patient safety, and the investigation plan. In addition, the CNO will review reports prior to submission to the regulatory body.

3. California Workforce Initiative Visit

Members of the research team from the California Workforce Initiative will be at SFGHMC on October 9, 2001. This group will be updating the January 2001 report entitled "Nursing in California: A Workforce Crisis" published by the Center for the Health Professions, University of California, San Francisco. The team will be reviewing nursing workload, workflow, and workforce issues. The Chief Nursing Officer, Nursing Director of Operations, Human Resources, Nurse Managers, and staff nurses will meet with the team members.

4. Diversion Summary Report

See attached.

San Francisco General Hospital

Diversion Report

September 2001

Executive Summary

The Emergency Department [ED] recorded 39 episodes of diversion for 165 hours representing a rate of 23% in **September 2001**. This is an 18% decrease in diversion since August 2001.

The 39 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from previous month
Total diversion	37	162	22.5%	15.5%
Trauma over-ride	2	3	0.5%	2.5%

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 186 patients were awaiting admission to in-patient beds [ICU-24 4B/StepDown-74 MedSurg-88]. In September of 2000, the ED was on diversion 37% of the month. Trauma Override was invoked 8% of the month in September 2000.

Total diversion was recorded for 37 episodes, a total of 162 hours or a 22.5% rate for September 2001.

Trauma override was recorded for 2 episodes, a total of 3 hours or a .5% rate for September 2001. This is a 2.5% decrease in trauma override from August 2001. While on Trauma override the ED held 302 patients awaiting inpatient beds.

Definitions:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSA definitions:

Total diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Pat Nagle R.N.
Base Hospital Coordinator

San Francisco General Hospital
Emergency Department
2001
Trauma Override Summary

The Emergency Department recorded 2 episodes of Trauma Override for
3 hours, a percentage of .5% for the month of September

Date	Length	Summary of Event
09/10/01	2258-0128	911-1
09/14/01	2110-2135	911-1 912-4

San Francisco General Hospital
Emergency Department
2001
Total Diversion Summary

In September Emergency Department recorded 37 episodes of Total Diversion
for 162 hours, a percentage of 22.5% for the month.

Date	Length	Summary of Event
09/02/01	0125-0510	37 patients in the ED Admits: 1-4B, 2-Floor Fast track-Open w/1Pedi ED waiting room: 10 urgent patients
09/02/01	1730-0145	29 patients in the ED Fast Track-Opened Admits: 2-ICU, 4-4B ED waiting room: 9 urgent patients
09/03/01	1950-0030	32 patients in the ED Admits: 6-Floor Fast track-Open ED waiting room: 11 urgent patients
09/04/01	0800-0956	40 patients in the ED Admits: 2-ICU, 5-Floor / critical care transport from UCSF Fast Track-Open ED waiting room: 6 urgent patients
09/04/01	1254-1920	33 patients in the ED Admits: 1-ICU, 3-4B ED waiting room: 0 patients
09/04/01	2050-0130	34 patients in the ED Admits: 4-4B, 3-Floor Fast track- Open ED waiting room: 15 urgent patients
09/05/01	1310-1924	35 patients in the ED Admits: 2-4B, 5-Floor Fast track- Open Ed waiting room: 9 urgent patients
09/06/01	1035-1330	27 patients in the ED Fast Track-Open Admits: 2-Floor ED waiting room: 4 urgent patients
09/06/01	1445-1640	32 patients in the ED Fast track-Open Admits: 2-4B Ed waiting room: 0 urgent patients
09/06/01	1800-0400	41 patients in the ED Fast Track-Open Admits: 6-Floor ED waiting room: 16 urgent patients
09/08/01	0105-0305	30 patients in the ED Fast track-Closed Admits: 1-4B ED waiting room: 7 urgent patients
09/09/01	1925-0010	28 patients in the ED Fast Track-Closed Admits: 2-ICU ED waiting room: 7 urgent patients

09/10/01	1740-2300	29 patients in the ED Fast Track- Closed Admits: 1-ICU, 1-4B, 4-Floor ED waiting room: 10 urgent patients
09/11/01	1330-1420	33 patients in the ED Fast Track-Open Admits: 0 ED waiting room: 4 urgent patients
09/11/01	1648-1820	29 patients in the ED Fast Track-Open Admits: 2-ICU, 2-4B ED waiting room: 3 urgent patients
09/12/01	1425-1545	26 patients in the ED Fast track-Open Admits: 2-4B ED waiting room: 0 urgent patients
09/13/01	1600-1820	32 patients in the ED Fast track-Open Admits: 1-ICU,1-4B, 1-Floor ED waiting room: 4 urgent patients
09/13/01	2055-0020	31 patients in the ED Fast Track-Open Admits: 2-4B, 2-Floor ED waiting room: 2 urgent patients
09/14/01	2025-0210	30 patients in the ED Fast Track -Closed Admits: 1-4B, 3-Floor ED waiting room: 7 urgent patients
09/15/01	2105-2255	27 patients in the ED Fast Track-Closed Admits: 1-Floor ED waiting room: 7 urgent patients
09/17/01	1648-1838	38 patients in the ED fast track-Open Admits: 4-4B, 6-Floor ED waiting room:0 urgent patients
09/19/01	1500-2135	33 patients in the ED Fast Track-Open Admits: 1-4B ED waiting room: 10 urgent patients
09/20/01	1515-1735	32 patients in the ED Admits: 2-ICU, 2-4B ED waiting room: 2 urgent patients
09/20/01	1915-2238	32 patients in the ED Fast Track-Open Admits: 1-4B ED waiting room: 2 urgent patients
09/21/01	1915-2015	35 patients in the ED Fast Track-Open Admits: 1-ICU, 4-Floor ED waiting room: 4 urgent patients
09/22/01	1307-1550	25 patients in the ED Fast Track-Open Admits: 2-ICU,4-4B ED waiting room:0 urgent patients
09/22/01	2151-0451	27 patients in the ED (multi-casualty /burn/inhalation/full arrest) 2 exp. Admits: 3-4B Fast Track -Closed ED waiting room: 4 urgent patients
09/23/01	2215-0640	30 patients in the ED Admits: 2-4B, 3-Floor Fast Tack- Closed ED waiting room: 0 urgent patients

09/23/01	2300-0646	31 patients in the ED Admits: 3-4B Fast Track – Closed/but holding 3 patients ED waiting room: 10 urgent patients
09/24/01	0957-0430	26 patients in the ED Admits: 3-4B, 1-Floor Fast Track-Open ED waiting room: 7 urgent patients
09/25/01	1425-0435	34 patients in the ED Admits: 1-ICU, 3-Floor Fast Track- Open ED waiting room: 14 urgent patients
09/26/01	1037-1537	22 patients in the ED Admits: 3-ICU, 6-4B Fast Track- Open ED waiting room: 7 urgent patients
06/26/01	1810-2045	28 patients in the ED Admits: 1-Floor Fast Track- Closed ED waiting room:0
09/27/01	1325-1815	47 patients in the ED(multi-casualty/MVA-Rollover – Yellow Alert) Admits: 4-4B, 4-Floor Fast Track- Open with 6 patients waiting ED waiting room: 3 urgent patients
09/28/01	1125-1325	48patients in the ED Admits: 1-4B, 8-Floor Fast Track-Open ED waiting room: 0
09/28/01	1415-1530	58 patients in the ED Admits: 2-4B, 8-Floor Fast Track-Open ED waiting room: 10 urgent patients
09/30/01	1840-0345	27 patients in the ED Admits: 2-ICU, 4-4B, 2-Floor Fast Track- Open @2300 ED waiting room: 12 urgent patients

ITEMS FOR BOARD INFORMATION	
TOPIC	DISCUSSION
Medical Staff Participation in the Events following the Tragic Events and Attack on 9/11/01	<p>Members discussed the mobilization of the SFGH Command Center in conjunction with Admin Team and MSSD.</p> <p>A memorandum from Tomas Aragon, MD, Dir. & Deputy County Health Officer concerning heightened surveillance Recommendations was distributed to the Medical Community.</p> <p>Dr. John Brown, MD of Dept of EMS will attend a future meeting of the MEC to address EMS and is working vigorously to ensure foolproof communication system. Dr. Brown is working closely with Mr. John Kaneley, Associate Administrator, Facilities.</p>
SFGHMC Guidelines for In-Patient Management of Opiod Dependent Patients	<p>The SFGHMC Substance Abuse Cmte, under Chairmanship of Dr. David Hersch, has developed guidelines for In-Patient Management of Opiod Dependent Patients. Dr. Hersch will be invited to attend a future meeting of the MEC to discuss these guidelines.</p> <p>A memorandum from Drs. K. Grumbach, Chief of FCM and Shieva Khayam Bayashi, Medical Director, 4A, was circulated to all service chiefs. Effective 10/1/01, in addition to the usual discharge summary, the transferring licensed physician will write Transfer Orders to 4A. The orders must be signed by a licensed physician.</p>
Transfer Summary to 4A – New policy for Transfer Orders	
TOPIC	DISCUSSION
Medical Staff Committee Reports	The activities of the MR subcommittee were presented with MEC discussion focusing on:
1. Med Rec Subcommittee	<i>P.I. Project – Improvement of Compliance with Verbal Orders</i> The goals of this project were to improve compliance rate to 80 percent by October 1, 2001.
2.. Tissue Subcommittee	The Quarterly Tissue Subcommittee report was reviewed.
CLINICAL Service Annual Reports	Drs. Talmage King, Chief of Medicine and Stuart Seiff, Chief of Ophthalmology, presented their Annual Clinical Service Reports to the MEC 10/1/01.
TOPIC	DISCUSSION
Other Issues	<p>MEC also held discussion relating to the following issues:</p> <ul style="list-style-type: none"> • Pilot Program relative to Instiutional Police & improved security within the facility • Avon Grant & the 1001 Foundation • A summary of the preliminary findings of the 2001 JCAHO Mock Survey, follow-up items and Action Plans. Due to the tragedy of 9/11/01, the Medical Staff portion of the survey was cancelled and is being rescheduled for sometime in October 2001. • The Space Project Management Process and the inclusion of a representative from MEC on the Space Management Committee.

Report submitted by: J. Renee Navarro, M.D, PharmD.
Chief of Staff

**SFGHMC MEDICAL EXECUTIVE COMMITTEES
SUMMARY OF MEETINGS OF:10/1/01 & 10/4/01**

ITEMS REQUIRING BOARD APPROVAL

TOPIC	DISCUSSION	ACTION
Credentialing Recommendations	Members reviewed and discussed credentialing recommendations received from October 2001 Credentials Committee. Privileges recommended were supported with appropriate documentation.	MEC recommends JCC/HC approval as presented.
Credentialing – INFORMATIONAL	<p>A. Dr. M. Neighbor, CoChair, CIDP, provided and update on the activities of the CIDP. Five standardized procedures were presented & approved</p> <ol style="list-style-type: none"> 1. Needlestick Hotline: Occupational Medicine 2. Nurse Midwife-Episiotomy & Perineal Laceration Repair 3. South East Health Center – Family Nurse Practitioner 4. Flexible Sigmoidoscopy/ Esophageal Manometry 5. Family Health Center Family Nurse Practitioner <p>B. Integrative Therapies Subcommittee – No report (appt of new Chair pending)</p> <p>C. Community Health Network – Dr. R. Fine, representing the CHN Managed Care QU Committee, reported no major incidents or QI issues pertaining to CHN managed Care providers during the months of August or Sept 2001.</p> <p>D. DEA Certification Requirement – Lengthy discussion with the Credentials Cmte supporting MS Bylaws requirement for DEA Certification for providers within services rendering patient care.</p> <p>E. Revision of the Surgical Privileges List – Credentials Chair to request Surgical Service Chief make necessary revisions to distinguish between Trauma Thoracic Surgery and Thoracic Surgery for Fellowship Surgeons.</p> <p>F. The issue of PES moonlighters was discussed. Permitting PES moonlighters to join the MS would entail a Bylaws revision.</p> <p>G. Ultrasound Task Force – Pending</p> <p>H. Parotid Surgery Task Force – Pending</p>	INFORMATIONAL
QUM Report	<p>Presented under separate cover by Dr. John Luce, Chair</p> <p>Note: A recommendation of the Patient Safety and Reduction of Medical Error plan is to change the name and composition of the QUM Committee. The suggested new name will be the Performance Improvement and Patient Safety Committee (PIPS), and will be expanded to include the Associate Administrators. This recommendation will involve revisions to the MS Bylaws.</p>	MEC recommends JCC/HC approval
Administrative Policy and Procedure Approval	Policies and procedures – presented under separate cover:	MEC recommends JCC/HC approval

**San Francisco General Hospital
Statement of Revenue and Expenses
Month ending September 30, 2001**

Overview:

Monthly Results:

Net Income, Page 1, Line 61, Column 3

Net Income for the month of September exceeds Budget by \$1,026,000. Patient service revenue continues to exceed budget, as was the case last year and is a result of continued high inpatient and outpatient volume, also in excess of budget. At the same time, the cost of personnel services and fringe benefits exceed budget as staffing cost increases to manage additional patient volume. Additional Net Patient Revenue of \$729,000 (line 18) is therefore offset by Personnel Services and Fringe Benefit expenses of \$544,000 (lines 35 & 36).

Gross Patient Revenue, Page 1, Line 8, Column 3

Gross patient revenue exceeded budget \$6,225,000 or 13.8%. This compares to a variance in average daily census of 7.1% (page 2, line 7).

Annual Projection:

Net Income, Page 1, Line 61, column 6

We are projecting \$2,641,000 net income for this fiscal year. This amount is based upon annualization of the continuing excess volume experienced last year and in the first quarter of this year, and the similar annualization of personnel expense variances discussed above.

Net Patient Service Revenue, Page 1, Line 18, Column 6

Projected net patient service revenue includes an additional \$2M in inpatient Medi-Cal Revenue. We have recently concluded negotiations on a Medi-Cal Contract increase that is expected to increase our 2001-2002 revenues \$4.2M. The \$2M increase to our projection therefore represents a conservative estimate of the annual impact. As we are only three months into the fiscal year, we are deferring a forecast of the full impact.

Other Operating Revenue, page 1, line 30, column 6

We have learned that our SB 1255 funding for 2001-2002 will be \$2M less than budgeted (and \$2M less than the previous year) and have reduced our projection accordingly.

Personnel Services, Page 1, Line 35, column 6

Projected expenses for the year are forecast to exceed budget by \$4,990,000 which largely is a result of additional staffing costs associated with additional inpatient volume.

Mandatory Fringe Benefits, Page 1, line 36, column 6

Projected Fringe Benefits for the year are also forecast to exceed budget, based on annualized YTD trends.

Statistical indicators:

Patient Days Page 2, Lines 25, 30, and 31

Patient days, excluding MHRF exceed budget 7.3%. Including the MMRF, patient days exceed budget 4.8%. Adjusted Patient Days, which factor in outpatient activity, exceed budget by 2.8%. This is consistent with the patient day variances for all of 2000-2001 and is expected to continue.

FTEs per adjusted occupied bed, Page 2, Line 43, column 6

FTEs per adjusted occupied bed are favorable compared to budget.

Days Revenue in Accounts Receivable, Page 2, Line 61, column 6

The investment in accounts receivable has increased to 89 days for September. This is within acceptable standards and significantly lower than levels seen in the prior year. We are setting a budget goal of 80 days for 2001-2002, which is aggressive, but believed to be achievable. We concluded 2000-2001 at 84 days however as of September 2000 our investment in AR was 111 days.

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/2002
 Month Ending: SEP 30, 2001
 (In Thousands of Dollars)

MONTHLY						ANNUAL					
Fav/(Unfav)						Fav/(Unfav)					
Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual	
GROSS PATIENT REVENUE:						GROSS PATIENT REVENUE:					
16,408	14,070	2,338	16.6%	15,335	Inpatient Medi-Cal Revenue	176,269	171,999	4,270	2.5%	153,288	
3,790	4,664	(874)	-18.7%	4,448	Outpatient Medi-Cal Revenue	48,167	56,751	(8,584)	-15.1%	50,578	
5,030	4,934	96	1.9%	4,557	Inpatient Medicare Revenue	62,756	60,321	2,435	4.0%	63,264	
1,885	1,836	49	2.7%	1,765	Outpatient Medicare Revenue	23,284	22,337	947	4.2%	23,428	
11,269	8,478	2,791	32.9%	6,171	Inpatient Other Revenue	138,168	103,635	34,533	33.3%	117,606	
5,563	4,633	930	20.1%	4,917	Outpatient Other Revenue	68,248	56,365	11,883	21.1%	63,963	
43,945	38,615	5,330	13.8%	37,193	TOTAL PATIENT SERVICE REVENUE	516,892	471,408	45,484	9.6%	472,127	
REVENUE DEDUCTIONS:						REVENUE DEDUCTIONS:					
7,467	6,396	(1,071)	-16.7%	5,141	Charity Care	87,825	76,680	(11,145)	-14.5%	80,219	
15,980	14,354	(1,626)	-11.3%	13,055	Provision for Medi-Cal Adjustments	175,565	175,229	(336)	-0.2%	161,290	
3,432	2,436	(996)	-40.9%	2,269	Provision for Medicare Adjustments	42,696	29,737	(12,959)	-43.6%	43,021	
5,062	3,855	(1,207)	-31.3%	5,259	Provision for Other Adjustments	62,072	48,463	(13,609)	-28.1%	54,599	
1,708	2,007	299	14.9%	1,917	Provision for Bad Debt	20,500	24,500	4,000	16.3%	19,022	
33,649	29,048	(4,601)	-15.8%	27,641	TOTAL REVENUE DEDUCTIONS	388,658	354,609	(34,049)	-9.6%	358,151	
10,296	9,567	729	7.6%	9,552	NET PATIENT SERVICE REVENUE	128,234	116,799	11,435	9.8%	113,976	
OTHER OPERATING REVENUE:						OTHER OPERATING REVENUE:					
710	710	0	n/a	663	Capitation/Managed Care Settlement	8,519	8,519	0	n/a	9,537	
421	421	0	n/a	548	Short Doyle	5,054	5,054	0	n/a	4,654	
0	0	0	n/a	0	MHRF Funding	0	0	0	n/a	0	
10,515	10,515	0	n/a	10,626	SB855	126,183	126,183	0	n/a	104,112	
1,642	1,808	(166)	-9.2%	1,808	SB1255	19,700	21,700	(2,000)	-9.2%	22,000	
108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300	
594	660	(66)	-10.0%	0	Revenue from Other City Departments	7,132	7,924	(792)	-10.0%	9,394	
0	0	0	n/a	854	Prior Year Settlement	362	0	362	n/a	(3,679)	
333	339	(6)	-1.8%	292	MAA & Other Net Patient Revenue	4,000	4,073	(73)	-1.8%	4,085	
14,323	14,561	(238)	-1.6%	14,899	TOTAL OTHER OPERATING REVENUE	172,250	174,753	(2,503)	-1.4%	151,403	
24,619	24,128	491	2.0%	24,451	TOTAL OPERATING REVENUE	300,484	291,552	8,932	3.1%	265,379	
OPERATING EXPENSES:						OPERATING EXPENSES:					
12,814	13,246	432	3.3%	12,314	Personnel Services	167,976	162,986	(4,990)	-3.1%	154,275	
3,073	3,185	112	3.5%	2,874	Mandatory Fringe Benefits	40,276	39,079	(1,197)	-3.1%	37,027	
7,722	7,722	0	n/a	9,927	Contractual Services	92,665	92,665	0	n/a	96,497	
2,022	2,022	0	n/a	2,489	Materials and Supplies (excl. Pharm.)	24,270	24,270	0	n/a	26,664	
1,167	1,167	0	n/a	1,000	Pharmaceuticals	14,000	14,000	0	n/a	12,710	
393	393	0	n/a	536	Facilities Maintenance & Capital Outlay	4,719	4,719	0	n/a	5,906	
1,399	1,399	0	n/a	1,312	Services of Other Departments	16,790	16,790	0	n/a	16,021	
(78)	(87)	(9)	-10.3%	(988)	Expenditure Recovery	(937)	(1,041)	(104)	-10.0%	(639)	
8,185	8,185	0	n/a	8,185	Operating Transfer Out	98,225	98,225	0	n/a	67,996	
427	427	0	n/a	187	Intrafund Transfer	5,129	5,129	0	n/a	2,248	
0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0	
635	635	0	n/a	611	Continuing Projects	7,618	7,618	0	n/a	5,131	
37,759	38,294	535	1.4%	38,447	TOTAL OPERATING EXPENSES	470,731	464,440	(6,291)	-1.4%	423,836	
(13,140)	(14,166)	1,026	7.2%	(13,996)	OPERATING INCOME/(LOSS)	(170,247)	(172,888)	2,641	1.5%	(158,457)	
NON-OPERATING REVENUE:						NON-OPERATING REVENUE:					
8,020	8,020	0	n/a	6,630	General Fund	96,245	96,245	0	n/a	81,090	
5,093	5,093	0	n/a	5,093	Realignment	61,113	61,113	0	n/a	61,113	
285	285	0	n/a	307	Prop 99	3,423	3,423	0	n/a	3,807	
484	484	0	n/a	205	Transfer In and Project-Related	5,765	5,765	0	n/a	2,723	
251	251	0	n/a	2,247	Carryforward	3,065	3,065	0	n/a	10,074	
73	73	0	n/a	73	Cafeteria	877	877	0	n/a	758	
200	200	0	n/a	235	Miscellaneous	2,400	2,400	0	n/a	2,439	
14,406	14,406	0	n/a	14,790	TOTAL NON-OPERATING REVENUE	172,888	172,888	0	n/a	162,004	
1,266	240	1,026	427.5%	794	NET INCOME/(LOSS)	2,641	0	2,641	n/a	3,547	

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/2002
Month Ending: SEP 30, 2001

CURRENT MONTH

Actual	Budget	Variance	% Var	Prior Year
1,389	1,395	(6)	-0.4%	1,421
1,866	1,960	(94)	-4.8%	2,028
193	176	17	9.7%	186
92	92	(0)	-0.2%	92
24	20	4	18.0%	24
309	288	21	7.1%	302
139	140	(1)	-0.9%	137
447	428	19	4.5%	439
7	7	(1)	-7.1%	6
6.7	6.4	(0.3)	-4.7%	6.4
0.000	1.295	(1.295)	-100.0%	1.216
46.0%	48.5%	-2.5%	-5.2%	53.2%
15.7%	17.5%	-1.8%	-10.1%	17.0%
38.3%	34.0%	4.3%	12.6%	29.8%
100.0%	100.0%	0.0%	n/a	100.0%
5,571	4,528	1,043	23.0%	5,115
1,987	1,952	35	1.8%	1,907
1,695	2,160	(465)	-21.5%	2,042
9,253	8,640	613	7.1%	9,064
5,939	5,104	835	16.4%	5,740
1,987	2,001	(14)	-0.7%	1,937
5,489	5,734	(245)	-4.3%	5,502
13,415	12,839	576	4.5%	13,179
18,024	18,040	(16)	-0.1%	18,807
83.3%	79.7%	3.6%	4.5%	81.8%
0	2,380	2,380	100.0%	2,275
0	329	329	100.0%	309
0	2,709	2,709	100.0%	2,584
334	334	0	n/a	334
334	3,043	2,709	89.0%	2,918
0.6	5.1	4.5	88.2%	4.7
\$ -	\$ 60,126	\$60,126	100.0%	\$58,644
24.0%	24.0%	0.0%	n/a	23.3%
0	227	(227)	-100.0%	337
\$ 1,366	\$ 1,337	\$29	2.2%	\$1,338
\$ 686	\$ 648	\$38	5.9%	\$671
\$ 13,195	\$ 12,308	\$887	7.2%	\$12,405
\$ 6,622	\$ 5,965	\$657	11.0%	\$6,220
\$ 2,095	\$ 2,102	\$7	0.3%	\$2,044
\$ 1,641	\$ 1,648	\$7	0.4%	\$1,609
\$ 20,236	\$ 19,347	(\$889)	-4.6%	\$18,959
\$ 15,849	\$ 15,171	(\$678)	-4.5%	\$14,923
31.0%	32.9%	1.9%	5.8%	36.5%
89	80	(9)	-11.3%	111

KEY VOLUME INDICATORS

Discharges (incl. MHRF)

Discharges (incl. MHRF)

Adjusted Discharges (incl. MHRF)

Average Daily Census

Acute Med/Surg ADC

Psych ADC

Skilled Nursing ADC

Total ADC excl. MHRF

MHRF ADC

Total Adult ADC

Nursery ADC

Average Length of Stay (excl. MHRF)

Medicare Case Mix Index

Payor Mix (Gross Revenue)

Medi-Cal

Medicare

Other

Total

Patient Days

Medi-Cal Patient Days (excl. MHRF)

Medicare Patient Days (excl. MHRF)

Other Patient Days (excl. MHRF)

Total Patient Days(excl. MHRF)

Medi-Cal Patient Days

Medicare Patient Days

Other Patient Days

Total Patient Days

Adjusted Patient Days

% Occupancy (available beds)

KEY OPERATIONAL INDICATORS

Labor

FTEs - Productive

FTEs - Non-Productive

Total FTEs - SFGH Only

UC Non-Academic FTEs

Grand Total FTEs Incl. UC

FTEs Per AOB (incl. UC)

Average Labor Cost per SFGH FTE

Fringe Benefits as % of Salary

Vacancy positions (as of the last PPE)

Revenues

Oper. Rev. Per Adjusted Patient Day (incl. MHRF)

Oper. Rev. (excl. SB855/1255/GME)/APD

Oper. Rev. Per Adjusted Discharge

Oper. Rev. (excl. SB855/1255/GME)/Adj. Discharge

Expenses

Operating Exp. Per Adjusted Pt. Day

Operating Exp.(excl. IGT)/Adj. Pt. Day

Operating Exp. Per Adj. Discharge

Operating Exp. (excl. IGT)/Adj Discharge

Supply Expense as % of Net Pt. Revenue

Days Revenue in Accounts Receivable*

YEAR-TO-DATE

Actual	Budget	Variance	% Var	Prior Year
4,190	4,316	(126)	-2.9%	4,552
5,760	6,049	(289)	-4.8%	6,417
195	180	15	8.4%	195
93	92	1	0.5%	95
25	20	5	26.5%	22
313	292	21	7.2%	312
139	140	(1)	-0.5%	134
452	432	20	4.7%	446
7	7	0	n/a	6
7.0	5.9	(1.1)	-18.6%	6.4
0.000	1.295	(1.295)	-100.0%	1.216
42.8%	48.5%	-5.7%	-11.7%	45.8%
16.4%	17.5%	-1.1%	-6.2%	17.4%
40.7%	34.0%	6.7%	19.8%	36.8%
100.0%	100.0%	0.0%	n/a	100.0%
16,111	14,064	2,047	14.6%	15,597
6,200	6,063	137	2.3%	6,168
6,494	6,710	(216)	-3.2%	6,963
28,805	26,837	1,968	7.3%	28,728
17,135	15,788	1,347	8.5%	17,512
6,200	6,190	10	0.2%	6,230
18,290	17,737	553	3.1%	17,314
41,625	39,715	1,910	4.8%	41,056
57,246	55,665	1,581	2.8%	57,878
84.2%	80.4%	3.8%	4.7%	83.1%
0	2,380	2,380	100.0%	2,290
0	329	329	100.0%	305
0	2,709	2,709	100.0%	2,595
334	334	0	n/a	334
334	3,043	2,709	89.0%	2,929
3.3	5.1	1.8	34.6%	4.7
\$ -	\$60,126	\$60,126	100.0%	\$ 58,565
24.0%	23.9%	-0.1%	-0.4%	23.0%
0	227	(227)	-100.0%	337
\$ 1,324	\$1,315	\$9	0.7%	\$1,279
\$ 682	\$645	\$37	5.7%	\$629
\$ 13,163	\$12,100	\$1,063	8.8%	\$11,538
\$ 6,775	\$5,934	\$841	14.2%	\$5,674
\$ 2,038	\$2,070	\$32	1.5%	\$1,912
\$ 1,609	\$1,628	\$19	1.2%	\$1,487
\$ 20,258	\$19,045	(\$1,213)	-6.4%	\$17,242
\$ 15,995	\$14,985	(\$1,010)	-6.7%	\$13,415
29.5%	32.7%	3.2%	9.8%	33.4%
89	80	(9)	-11.3%	111

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

Roma P. Guy, M.S.W.
President

Edward A. Chow, M.D.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

Tel. (415) 554-2666
FAX (415) 554-2665

Web Site: <http://www.dph.sf.ca.us>
E-mail: health_commission@dph.sf.ca.us

AMENDED AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, November 13, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

NOV 13 2001

SAN FRANCISCO
PUBLIC LIBRARY

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF OCTOBER 9, 2001
**Minutes of October 9, 2001*
- 3) FOR DISCUSSION: ANNUAL REPORT OF SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER (FY 2000-01)
(Gene O'Connell, Executive Administrator, SFGHMC)
**Report*
- 4) FOR DISCUSSION PHARMACY PBM SYSTEM: 12-MONTH STATUS REPORT
(Sharon Kotabe, CHN Director of Pharmaceutical Services)
**Report*
- 5) FOR DISCUSSION: SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER SB1953 COMPLIANCE PLAN
(Carlos Villalva, Chief Architect, SFGHMC)
**Report*

- 6) **FOR DISCUSSION:** **SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER ANNUAL COMPETENCY REPORT (FY 2000-01)**
(Rod Auyang, Human Resources Operations and Merits Manager)
**Report*
- 7) **FOR DISCUSSION:** **SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER ANNUAL ENVIRONMENT OF CARE REPORT (FY 2000-01)**
(John Kanaley, Associate Administrator for Support Services)
**Report*
- 8) **FOR DISCUSSION:** **SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER POLICIES AND PROCEDURES: HOSPITAL PLAN FOR THE PROVISION OF PATIENT CARE; PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS); AND UTILIZATION MANAGEMENT**
(Sue Currin, RN, Chief Nursing Officer; John Luce, MD, Medical Director for Quality Management)
**Policies and Procedures*
- 9) **FOR DISCUSSION** **SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER PERFORMANCE IMPROVEMENT REPORT**
(John Luce, M.D., Medical Director for Quality Management)
**Report*
- 10) **PUBLIC COMMENT****
- 11) **CLOSED SESSION**

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **APPROVAL OF CLOSED SESSION MINUTES OF OCTOBER 9, 2001**

FOR DISCUSSION: **CONSIDERATION OF CREDENTIALING MATTERS**

J. Renee Navarro, M.D., Chief of Staff, SFGHMC
Hiroshi Tokubo, CHN Director, QM

D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session. (San Francisco Administrative Code Section 67.12(b)(2).)

12) ADJOURNMENT

- * Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.
- * Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at:

Sunshine Ordinance Task Force
Donna Hall, Administrator
City Hall, Room # 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

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HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor
Department of Public Health



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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, November 13, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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1) CALL TO ORDER

The San Francisco General Hospital Joint Conference Committee meeting was called to order by Commissioner John I. Umekubo, M.D. at 3:55 p.m.

Present: Commissioner John I. Umekubo, M.D.

Absent: Commissioner Lee Ann Monfredini

Staff: Rod Auyang, Sue Currin, Doug Eckman, Kathy Eng, Fred Hom, Janise Ito, John Kanaley, Judith Klain, Sharon Kotabe, John Luce, M.D., Beth Maloney, Alison Moed, Kathleen Murphy, J. Renee Navarro, M.D., Gene O'Connell, Gregg Sass, Hiroshi Tokubo, Carlos Villalva, Chris Wachsmuth, Connie Young, Monique Zmuda.

2) APPROVAL OF MINUTES OF OCTOBER 9, 2001

Action Taken: The committee approved the minutes of the October 9, 2001 San Francisco General Hospital Joint Conference Committee.

3) **ANNUAL REPORT OF SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER (FY 2000-01)**

Gene O'Connell, Executive Administrator for SFGHMC, presented the Annual Report. Ms. O'Connell stated that the hospital's vision is "to be the best public hospital in the country" and highlighted various programs that further the Department's Strategic Plan goals.

Commissioners' Comments

- Commissioner Umekubo commented that, for the presentation to the full commission, the report should also highlight medical education and training activities and San Francisco General Hospital, since these activities are such integral parts of the fabric of services.

4) **PHARMACY PBM SYSTEM: 12-MONTH STATUS REPORT**

Sharon Kotabe, CHN Director of Pharmaceutical Services, updated the committee on the pharmacy PBM system. She stated that the Department is continuing to lobby the federal government for preferential price treatment for PBM pharmacies. She also said that the Department will be coming before the Health Commission in December for approval to modify the contract with Pharmaceutical Care Network to increase the contract by \$1.5 million, and shorten the term of the contract to 15 months.

5) **SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER SB1953 COMPLIANCE PLAN**

Carlos Villalva, Chief Architect, presented San Francisco General Hospital's SB 1953 Compliance Plan. The hospital is on schedule to submit the compliance plan to the State by December 31, 2001. Mr. Villalva stated that there are a number of planning efforts underway that will impact the plan however, so it is likely that the SB 1953 compliance plan will have to be amended. This can be done until July 1, 2004. Mr. Villalva said that the Department has given itself to the end of 2002 to evaluate up to six scenarios.

Commissioners' Comments

- Commissioner Umekubo stated that earlier in 2001, there was an expedited effort to get a rebuild plan approved by the Health Commission, which was then suddenly taken off the table, and asked why this had happened. Mr. Villalva responded that there had been a quick mobilization to respond to the requirements of SB 1953. However, after receiving approval in April from the Health Commission, a number of people thought that more time should be taken to answer the programmatic questions that go beyond the scope of the physical plant. Gene O'Connell added that a lot of questions were raised last year that the current planning efforts will help answer.

6) **SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER ANNUAL COMPETENCY REPORT (FY 2000-01)**

Rod Auyang, Human Resources Manager, presented the 2000-2001 Competency Report. He highlighted the requirement for annual performance evaluations of all employees working at San Francisco General. 98% of employees were assessed for their performance in a timely manner. Mr. Auyang stated that this is 8% increase from the previous year. For the employees whose performance appraisals were completed in a timely manner, 47.5% "exceeded expectations" and 51.2% "met expectations." Only 1.3% of employees did not meet expectations. For these employees, Mr. Auyang

said that they expect the manager to communicate with employees specifically what the problems are, and work to improve their standards.

Commissioners' Comments

- Commissioner Umekubo asked if the evaluation tool was a factor in non-compliance. Mr. Auyang responded that managers had thought the previous employee evaluation tool was too cumbersome, but another factor was the number of employees some managers had to evaluate.

7) SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER ANNUAL ENVIRONMENT OF CARE REPORT (FY 2000-01)

John Kanaley, Associate Administrator for Support Services, presented the Annual Environment of Care report. Mr. Kanaley summarized the seven disciplines of the EOC, and highlighted the Life Safety discipline, which is one of the areas of most concern. Mr. Kanaley stated that the other area of significant concern is Utility Management, particularly the Power Plan. He said that the Power Plant is beyond its economic life—it was designed in the 1960s and is inefficient and broken down. The Mayor has earmarked \$40 million in the Public Utilities Commission's budget for the replacement of the plant. Mr. Kanaley said that a key priority is to make sure this money remains available for this purpose.

8) SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER POLICIES AND PROCEDURES: HOSPITAL PLAN FOR THE PROVISION OF PATIENT CARE; PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS); AND UTILIZATION MANAGEMENT

Sue Currin presented the Hospital Plan for the Provision of Patient Care. The goal of this plan is to coordinate patient care in a manner that is seamless from the patient's perspective. John Luce, M.D., presented the Performance Improvement and Patient Safety (PIPS) Program, and utilization management program. Dr. Luce stated that, in response to new JCAHO standards, the Quality Management Program was revised to include the new requirements, and the names was changed to PIPS to include the terms "patient performance" and "patient safety," both of which are part of the new JCAHO terminology. Dr. Luce stated that there are no significant changes in the inpatient Utilization Review program.

Action Taken: The Committee approved the San Francisco General Hospital Medical Center policies and procedures: Hospital Plan for the Provision of Patient Care; Performance Improvement and Patient Safety Program (PIPS); and Inpatient Utilization Review Program.

9) SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER PERFORMANCE IMPROVEMENT REPORT

John Luce, M.D., presented the San Francisco General Hospital Medical Center Performance Improvement Report.

10) PUBLIC COMMENT

None.

11) **CLOSED SESSION**

A) **Public Comments on All Matters Pertaining to the Closed Session**

None.

B) **Vote on Whether to Hold a Closed Session**

Action Taken: The Committee voted to hold a closed session.

The Committee went into closed session at 5:40 p.m. People present in the closed session were the same as those present in open session.

C) **Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1**

CLOSED SESSION MINUTES OF OCTOBER 9, 2001

CONSIDERATION OF CREDENTIALING MATTERS

J. Renee Navarro, M.D., Chief of Staff, SFGHMC
Hiroshi Tokubo, CHN Director, QM

Action Taken: The Committee approved the closed session minutes of October 9, 2001 and the November 2001 Credentials Report.

D) **Reconvene in Open Session**

The Committee reconvened in open session at 5:49 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session. (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in closed session.

12) **ADJOURNMENT**

The meeting was adjourned at 5:50 p.m.



Michele M. Olson
Executive Secretary to the Health Commission

Roma P. Guy, M.S.W.
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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, December 11, 2001
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF NOVEMBER 13, 2001
**Minutes of November 13, 2001*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Office)
**Report*
- 5) FOR DISCUSSION: MEDICAL STAFF REPORT
(J. Renee Navarro, M.D., Chief of Staff)
**Report*

- 6) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
**Report*

7) CLOSED SESSION

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: APPROVAL OF CLOSED SESSION MINUTES OF NOVEMBER 13, 2001

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE AND CREDENTIALING MATTERS

J. Renee Navarro, M.D., Chief of Staff, SFGHMC
John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

- D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

8) ADJOURNMENT

- * Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.
- * Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

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Telephone: (415) 554-7724
Fax: (415) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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MINUTES

**JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING**

**Tuesday, December 11, 2001
3:45 p.m.**

**1001 Potrero, Conference Room #2A6
San Francisco, CA 94110**

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1) CALL TO ORDER

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

Staff: Cathy Chou, Sue Currin, Myra Garcia, Philip Hopewell, M.D., Beth Maloney, Alison Moed, Kathleen Murphy, J. Renee Navarro, M.D., Gene O'Connell, Roland Pickens, Gregg Sass, Hiroshi Tokubo and Connie Young.

2) APPROVAL OF MINUTES OF NOVEMBER 13, 2001

Action Taken: The Committee approved the minutes of the November 13, 2001 San Francisco General Hospital Joint Conference Committee.

**3) HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)**

Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center, presented the Hospital Healthcare Update. Ms. O'Connell introduced and the Committee welcomed Roland Pickens, who was recently appointed Associate Hospital Administrator for Diagnostic Services.

PROGRAM UPDATES

Appointment of New Hospital Associate Administrator

Roland Pickens has been appointed to the position of Associate Hospital Administrator for Diagnostic Services. The effective date of this appointment was December 3, 2001. In this position, Roland will be responsible for all of SFGHMC Diagnostics, including the Departments of Radiology, Nuclear Medicine, Infection Control, Clinical Laboratory, Pathology, and Medical Specialty Clinics in Pulmonary, GI, Cardiology, and Dermatology and other duties as assigned.

Roland brings to the organization a unique and timely combination of skills and experience. He earned a Bachelor of Science degree in Public Health from Dillard University, a Master of Health Administration degree from the Tulane University School of Public Health and Tropical Medicine. His professional experience in health care management spans the broad spectrum, encompassing positions within the for-profit hospital industry, including psychiatric and substance abuse programs, not-for profit and academic medical centers, the Veterans Administration system, and the Department of Public Health. He has organized and directed clinical programs involving primary care, medical and surgical specialties, and rehabilitation services. In addition, Roland brings a strong background in health care financial management. He is active in several professional associations and most notably serves on the Golden Gate Regent's Advisory Council of the American College of Healthcare Executives.

REGULATORY AND ACCREDITATION VISITS UPDATE

American College of Surgeons Trauma Level I Designation Consultative Survey

The American College of Surgeons [ACS] conducted a consultative site visit on November 15 and 16 in preparation for SFGH's re-verification as a Level 1 Trauma Center in 2002. The ACS survey team consisted of two trauma surgeons, a neurosurgeon and a trauma program manager, all of whom are practicing trauma professionals at major trauma centers in the United States. The consultation visit included a 4-hour interview session with SFGH Administration and Trauma Center physicians leaders; a 3-hour medical record review to evaluate the documented care of adult and pediatric patients with complex injuries; survey of key trauma departments [ED, Radiology, OR, PAR, ICU, Rehabilitation] and a 2-hour exit conference reviewing the team's findings. The ACS survey team identified that SFGH should prepare for a re-verification and Level 1 trauma designation visit within 12 months of this consultation [i.e., November 2002]. Areas for improvement were identified in the following areas: documentation of education, trauma certifications, multidisciplinary physician peer review and continuity of patient care. The ACS surveyors strongly endorsed the need for aero-medical transport into the Trauma Center and identified this service gap as a key vulnerability in San Francisco's trauma system. The surveyors also commented on areas of strength in the SFGH program to include: research in trauma care, commitment by SFGH Neurosurgeons, excellence of SFGH Trauma Coordinator Carol Shagoury, strength of Administrative support for the Trauma Program and the CDC funded Injury Center and its prevention programs. An action plan is being developed to address the areas where improvement is needed to prepare for the last step in the Trauma Center re-verification and designation process.

American College of Surgeons Cancer Survey

The American College of Surgeons (ACS) was also to conduct the Cancer Accreditation Survey this year. The Cancer Survey was originally scheduled for November 2nd but was rescheduled by ACS due to a death of an ACS associate. The new date is calendared for January 25, 2001.

Having been focused on the November 2nd date, the Department of Medicine- Oncology and Quality Management is well prepared for the January 25th Cancer Accreditation Survey. They will be utilizing the time from now until the January 25th to strengthen and perform further analysis on data collected in the Cancer Registry.

Commissioners' Comments

- Commissioner Monfredini expressed that she was extremely proud of everyone for the December 4th Health Commission meeting at San Francisco General Hospital. An extraordinary amount of information and background was presented in a very comprehensive manner.

4) PATIENT CARE REPORT

Sue Currin presented the Patient Care Report, (Attachment A). Ms. Currin highlighted the section on the use of physical restraints and stated that, per JCAHO standards, there are two categories of restraints: medical-safety and behavioral. Medical-safety restraints are used as protective interventions related to a medical condition or symptom. Behavioral restraints are utilized in crisis situations when the patient's behavior presents an immediate, serious danger to the patient's safety or the safety of others. Ms. Currin said that the incidence of restraint use has decreased except in the area of critical care. Ms. Currin highlighted recommendations regarding the restraint issue:

1. Refine statistical indicators used in performance monitoring:
 - Ongoing performance data will be monitored using the CalNOC Physical Restraint Prevalence Study that will allow for comparison to other CalNOC institutions
 - Psychiatry to start collecting data on purpose of restraint
 - Duration data to be calculated as median.
2. Continue performance monitoring related to:
 - Usage (prevalence, purpose, duration)
 - Clinical appropriateness, least restrictive interventions utilized
 - Compliance with policy and procedure.

Ms. Currin stated that educating staff on the use of restraints is one of her priorities on her daily rounds.

Ms. Currin also discussed mandatory overtime, which has been reduced by two thirds since January 2001. However there are two problem areas: the Mental Health Rehabilitation Facility and Psychiatry.

Commissioners' Comments

- Commissioner Monfredini asked if there are different sets of rules governing when to use restraints for different parts of the hospital. Ms. Currin responded that there is one standard of care for all areas, including the emergency room and PES.

- Commissioner Umekubo noted that it was interesting that mandatory overtime was clustered in Psychiatry. Mr. Currin responded that new regulations require 1:1 observation of restrained patients in Psychiatry. Fixed staffing positions are not enough to cover this requirement, and though they make every effort to use Registry and Per Diem nurses, often must use mandatory overtime.

5) MEDICAL STAFF REPORT

The Medical Staff Report was presented in Closed Session.

6) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES

Gregg Sass, CHN Chief Financial Officer, presented the Statement of Revenue and Expenses for October 2001, (Attachment B). Mr. Sass stated that they are still anticipating a significant year-end surplus, conservatively estimated at \$5.6 million.

Commissioners' Comments

- Commissioner Monfredini, commenting on the time it is taking for SFGH requisitions to get approved, asked why City Hall seems not to understand that the use of Registry staff, overtime, etc. costs more than utilizing authorized positions. This is particularly troublesome given the fact that the hospital has the money to cover these costs. Mr. Sass responded that the Controller's Office does not feel that they have the authority to approve positions that are not part of the approved budget, and are requiring DPH to go through the supplemental appropriation process.

7) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

None.

B) Vote on Whether to Hold a Closed Session

Action Taken: The Committee voted to hold a Closed Session.

The Committee went into Closed Session at 4:30 p.m. People present in the Closed Session were the same as those present in Open Session, with the exception of Gregg Sass.

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

CLOSED SESSION MINUTES OF NOVEMBER 13, 2001

Action Taken: The Committee approved the Closed Session minutes of November 13, 2001.

**CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE,
QUALITY ASSURANCE AND CREDENTIALING MATTERS**

Action Taken: The Committee approved the December 2001 Credentials Report.

D) **Reconvene in Open Session**

The Committee reconvened in Open Session at 5:55 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in Closed Session.

8) **ADJOURNMENT**

The meeting was adjourned at 5:55 p.m.



Michele M. Olson

Executive Secretary to the Health Commission

Attachments (2)

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 12/11/01

Sue Currin, RN, MS, Chief Nursing Officer

1. PHYSICAL RESTRAINTS

Restraint is defined as any method (chemical or physical) of restricting an individual's freedom of movement, physical activity or normal access to the body. Performance monitoring for all areas utilizing restraint was completed in May 2001 and October and November 2001. Four areas of the hospital utilize restraint when clinically indicated. These are the Emergency Department, Critical Care Units 4E, 5E/5R, and Critical Care Stepdown Unit 4B, Medical Surgical Units 4D, 5A, 5C, 5D, and 6A and Acute Psychiatry which includes the Psychiatric Emergency Service and inpatient units 6B, 7A, 7B, 7C and 7L the Psychiatric Forensic Unit. Patients in each of these areas experience differing types of medical conditions with resultant behaviors that place the patient or care providers at risk for injury, resulting in the use of restraints. The Mental Health Rehabilitation Facility and Women's and Children's Services do not utilize restraint.

As a result of HCFA and JCAHO standards, restraints are delineated by hospital policy into two categories: medical-safety and behavioral. Medical-safety restraints are used for the purpose of limiting mobility or temporarily immobilizing a patient following a procedure. Medical-safety restraints are used as protective interventions related to a medical condition or symptom. Behavioral restraints are utilized in crisis situations when the behavior of the patient is aggressive or violent presenting an immediate, serious danger to the patient's safety or that of others.

Due to the differing scope of service for the various areas, comparison of restraint incidence or duration between areas may not yield valid conclusions. For all areas the incidence and duration of restraint usage was monitored. An incident is defined as the time from the initiation of the restraint as noted on a monitoring flow sheet or log, with the accompanying physician's order, to the time that the restraint is removed from the patient. This does not include the time when the restraint is removed from the patient for range of joint motion or hands on clinical intervention.

Restraint Incidence

	May 2001	Sep/Oct 2001
Inpatient Psychiatry	24/65 = 15%	19/144 = 13%
7L	9/49 = 18%	8/55 = 15%
PES	47/487 = 10%	49/559 = 9%
Med-Surg	7%	7%
Critical Care	15%	21%
ED	NA	2%

that med-surg and critical care would use predominantly medical safety restraint. The incidence of behavioral restraint increased in med-surg from May to October. This is most likely a result of staff's improved understanding of the definition of behavioral restraint. Due to the severe nature of patient's conditions in the critical area behavioral restraint would be rarer except on 4B.

Available data indicates a decrease in the duration of restraint, which may indicate a trend toward less restrictive care.

Recommendations

1. Refine statistical indicators used in performance monitoring:
 - Ongoing performance data will be monitored using the CalNOC Physical Restraint Prevalence Study that will allow for comparison to other CalNOC institutions.
 - Psychiatry to start collecting data on purpose of restraint
 - Duration data to be calculated as median
2. Continue performance monitoring related to:
 - Usage (prevalence, purpose, duration)
 - Clinical appropriateness, least restrictive interventions utilized
 - Compliance with policy and procedure: physician orders and documentation

2. MANDATORY OVERTIME & RN/LVN-LPT VACANCY RATE

Mandatory overtime occurs when an employee is required to work longer than the normal work day or longer than the normal workweek due to patient care needs and staffing. Nursing makes a good faith effort to utilize Per Diem Nurses, voluntary overtime, registry or other appropriate licensed personnel in order to avoid mandatory overtime.

Mandatory overtime incurred between 5/1/01 and 11/15/01:

AREA		MANDATORY OT	RN VAC RATE	LVN-LPT VAC RATE
Med-Surg	=	17 hours	2.9%	7.0%
Labor & Delivery	=	70 hours	3.0%	0.0%
4A SNF	=	4 hours	11.0%	0.0%
MHRF	=	320 hours	14.0%	11.0%
Psychiatry	=	913 hours	8.0%	11.0%
TOTAL	=	1,326 hours	Overall 8.0% (~46 FTE)	11.0% (~25FTE)

There are approximately 140 FTE vacancies in nursing (~10% total overall vacancy rate).

Recruitment efforts continue with advertisement on the NurseWeek Web Site, participation in open houses at local schools/conferences and work on H1B/Canadian Visas.

Restraint Incidence was calculated using the following formula:
 $\# \text{ patients restrained} / \# \text{ patients treated} \times 100$

Purpose of Restraint

	Behavioral May 2001	Medical- Safety May 2001	Behavioral October 2001	Medical- Safety October 2001
Psychiatry	NA	NA	NA	NA
Med-Surg	0	100%	7%	93%
Critical Care	0	100%	0	100%
ED	NA	NA	4%	96%

Duration of Restraint

	May 2001	October 2001
Psychiatry(median)	4.6 hrs	3.2 hrs
Med-Surg	47.72 hrs	20.55 hrs
Critical Care	42.78 hrs	28.9 hrs
ED(median)	NA	4 hrs

Discussion

The restraint data documented above represent two "snapshots" of restraint usage. One must use caution in defining trends from this limited amount of data. All areas are conducting ongoing monitoring which will allow for trending of data, with conclusions related to clinical practice.

In Psychiatry, PES has the lowest rate of restraint followed by the inpatient units. Unit 7L functions somewhat like an Emergency Room with patients arriving in severely decompensated conditions, without being medicated and in severely stressful conditions. These patients therefore have required greater frequency and increased duration of restraint.

The incidence of restraint in both the Medical-surgical and Critical Care areas increased from May to October however, this may not reflect a trend in patient care but rather improved data collection and tracking of physician orders. It may also reflect the trend of shortening the duration of each restraint incidence with an increased number of incidences. This can actually indicate less restrictive patient care, allowing the patient more frequent times when they are free of restraint in response to improvements in the patient's behavior.

Due to the volume of patients seen and the length of stay in the emergency setting, PES and the ED have the lowest incidence and duration of restraint.

Educating staff as to the distinctions between medical-safety and behavioral restraint has been an ongoing process. Due to scope of service, one would expect that Psychiatry would have significantly more behavioral restraint than other areas of the hospital. One would also expect

The SFGHMC Labor Monitoring Committee reviews staffing compliance with HPPDs (Hours Per Patient Day) and acuity, in addition to the use of mandatory overtime. Based on a survey completed by Human Resources, by 6/02 the SFGHMC RN salary scale will be the lowest among Bay Area hospitals. The union has expressed a desire to discuss contract salary rate adjustments with the City.

3. DIVERSION SUMMARY REPORT

See attached.

Ptcare 12-11-01.doc

San Francisco General Hospital

Diversion Report

November 2001

Executive Summary

The Emergency Department [ED] recorded 39 episodes of diversion for 191 hours representing a rate of 27% in November 2001. This is a 5% decrease in diversion since October 2001.

The 39 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from previous month
Total diversion	39	191	27%	5%
Trauma Override	0	0	0	0

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 173 patients were awaiting admission to in-patient beds [ICU-11, 4B/StepDown-59, MedSurg-103]. In November of 2000, the ED was on diversion 25% of the month. Trauma Override was invoked 1% of the month in November 2000.

Total diversion was recorded for 39 episodes, a total of 191 hours or a 27% rate for November 2001.

Trauma override was recorded for 0 episodes, a total of 0 hours or a 0% rate for November 2001. This is a 1.6% decrease in trauma override from October 2001.

San Francisco General Hospital
Emergency Department
November 2001
Total Diversion Summary

In November the Emergency Department recorded 39 episodes of
Total Diversion for 191 hours, a percentage of 27% for the month.

Date	Length	Summary of Event
11/01/01	1350-1545	35 patients in the ED Admits: 1-4B; 5-Floor Fast Track: Open ED waiting room: 1 urgent patient
11/01/01	1740-2250	35 patients in the ED Admits: 2-4B; 4-Floor Fast Track: Open ED waiting room: 1 urgent patient
11/02/01	0023-0400	27 patients in the ED Admits: 4-4B; 7-Floor Fast Track: Closed ED waiting room: 12 urgent patients
11/02/01	1115-1815	31 patients in the ED Admits: 12-Floor Fast Track: Open ED waiting room: 10 urgent patients
11/03/01	1425-1700	24 patients in the ED Admits: 1-4B Fast Track: Closed ED waiting room: 4 urgent patients
11/05/01	1310-1550	32 patients in the ED Admits: 2-4B Fast Track: Open ED waiting room: 6 urgent patients
11/06/01	1450-2205	33 patients in the ED Admits: 3-4B Fast Track: Open ED waiting room: 8 urgent patients
11/07/01	1015-1345	29 patients in the ED Admits: 3-4B; 1-Floor Fast Track: Open ED waiting room: 2 urgent patients
11/07/01	1516-2100	35 patients in the ED Admits: 1-ICU; 4-4B; 1-Floor Fast Track: Open ED waiting room: 2 urgent patients
11/07/01	2150-0030	28 patients in the ED Admits: 1-ICU Fast Track: Closed ED waiting room: 0 urgent patients
11/08/01	1505-0055	29 patients in the ED Admits: 2-4B; 1-Floor Fast Track: Closed ED waiting room: 9 urgent patients
11/09/01	1505-2130	28 patients in the ED Admits: 0 Fast Track: Open ED waiting room: 0 urgent patients

11/10/01	1145-1910	36 patients in the ED Admits: 2-Floor Fast Track: Open ED waiting room: 0 urgent patients
11/11/01	1445-1615	30 patients in the ED Admits: 2-4B Fast Track: Closed ED waiting room: 0 urgent patients
11/11/01	1900-0045	28 patients in the ED Admits: 2-4B; 4-Floor Fast Track: Closed ED waiting room: 5 urgent patients
11/12/01	1145-1610	40 patients in the ED Admits: 1-ICU Fast Track: Closed ED waiting room: 0 urgent patients
11/12/01	1845-2040	36 patients in the ED Admits: 1-ICU; 2-4B; 3-Floor Fast Track: Closed ED waiting room: 0 urgent patients
11/13/01	1306-1810	38 patients in the ED Admits: 1-4B Fast Track: Open ED waiting room: 10 urgent patients
11/13/01	1915-2300	30 patients in the ED Admits: 2-4B; 3-Floor Fast Track: Closed ED waiting room: 7 urgent patients
11/14/01	0100-0300	0 patients in the ED Admits: 0 Fast Track: Closed ED waiting room: 0 urgent patients
11/14/01	1102-1318	34 patients in the ED Admits: 0 Fast Track: Open ED waiting room: 5 urgent patients
11/14/01	1422-1820	29 patients in the ED Admits: 1-4B; 1-Floor Fast Track: Open ED waiting room: 0 urgent patients
11/16/01	1530-2345	36 patients in the ED Admits: 1-ICU; 2-4B; 4-4-Floor Fast Track: Open ED waiting room: 10 urgent patients
11/17/01	0315-0735	18 patients in the ED Admits: 1-4B; 5-Floor Fast Track: Closed ED waiting room: 10 urgent patients
11/17/01	1430-2120	34 patients in the ED Admits: 1-4B; 5-Floor Fast Track: Closed ED waiting room: 6 urgent patients
11/18/01	0300-0645	32 patients in the ED Admits: 3-4B; 3-Floor Fast Track: Closed ED waiting room: 10 urgent patients
11/18/01	1925-0130	30 patients in the ED Admits: 1-ICU; 1-4B; 5-Floor Fast Track: Closed ED waiting room: 10 urgent patients
11/19/01	1410-2100	31 patients in the ED Admits: 0 Fast Track: Open ED waiting room: 5 urgent patients

11/21/01	1535-1900	26 patients in the ED Admits: 2-ICU Fast Track: Open ED waiting room: 0 urgent patients
11/21/01	2330-0330	29 patients in the ED Admits: 2-4B Fast Track: Closed ED waiting room: 0 urgent patients
11/23/01	1700-2125	34 patients in the ED Admits: 1-ICU; 2-Floor Fast Track: Open ED waiting room: Open
11/24/01	1540-1755	27 patients in the ED Admits: 1-ICU; 3-4B Fast Track: Closed ED waiting room: 4 urgent patients
11/26/01	1330-0235	32 patients in the ED Admits: 1-ICU; 7-4B; 1-Floor Fast Track: Open ED waiting room: 7 urgent patients
11/27/01	1325-2215	23 patients in the ED Admits: 1-4B; 4-Floor Fast Track: Open ED waiting room: 13 urgent patients
11/28/01	1230-1840	36 patients in the ED Admits: 1-4B; 1-Floor Fast Track: Open ED waiting room: 3 urgent patients
11/28/01	1920-0145	28 patients in the ED Admits: 12-Floor Fast Track: Open ED waiting room: 5 urgent patients
11/29/01	2000-0046	22 patients in the ED Admits: 1-4B; 8-Floor Fast Track: Closed ED waiting room: 10 urgent patients
11/29/01	1235-1630	29 patients in the ED Admits: 1-ICU; 3-Floor Fast Track: Open ED waiting room: 3 urgent patients
11/30/01	1630-1750	34 patients in the ED Admits: 5-Floor Fast Track: Closed ED waiting room: 0 urgent patients

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/2002
Month Ending: OCT 31, 2001

CURRENT MONTH						YEAR-TO-DATE					
	Actual	Budget	Variance	% Var	Prior Year		Actual	Budget	Variance	% Var	Prior Year
KEY VOLUME INDICATORS											
<u>Discharges (incl. MHRF)</u>											
1	1,358	1,439	(81)	-5.6%	1,443	Discharges (incl. MHRF)	5,548	5,755	(207)	-3.6%	5,995
2	1,955	2,023	(68)	-3.4%	2,052	Adjusted Discharges (incl. MHRF)	7,715	8,072	(357)	-4.4%	8,469
<u>Average Daily Census</u>											
4	190	176	14	8.1%	191	Acute Med/Surg ADC	194	179	15	8.3%	194
5	93	92	1	0.9%	89	Psych ADC	93	92	1	0.7%	93
6	26	19	7	38.9%	19	Skilled Nursing ADC	26	20	6	28.0%	22
7	309	287	22	7.8%	299	Total ADC excl. MHRF	312	291	21	7.3%	309
8	139	140	(1)	-0.7%	136	MHRF ADC	139	140	(1)	-0.5%	134
9	448	427	21	5.0%	435	Total Adult ADC	451	431	20	4.7%	443
10	7	7	(1)	-7.1%	7	Nursery ADC	7	7	0	n/a	7
11	7.2	6.4	(0.8)	-12.5%	6.5	Average Length of Stay (excl. MHRF)	7.0	5.8	(1.2)	-20.7%	6.4
12	0.000	1.295	(1.295)	-100.0%	1.132	Medicare Case Mix Index	0.000	1.295	(1.295)	-100.0%	1.132
<u>Payor Mix (Gross Revenue)</u>											
16	49.3%	48.5%	0.8%	1.6%	54.4%	Medi-Cal	44.5%	48.5%	-4.0%	-8.3%	47.9%
17	16.2%	17.5%	-1.3%	-7.3%	16.5%	Medicare	16.4%	17.5%	-1.1%	-6.5%	17.2%
18	34.5%	34.0%	0.5%	1.4%	29.2%	Other	39.2%	34.0%	5.2%	15.2%	34.9%
19	100.0%	100.0%	0.0%	n/a	100.0%	Total	100.0%	100.0%	0.0%	0.0%	100.0%
<u>Patient Days</u>											
22	5,592	4,663	929	19.9%	6,260	Medi-Cal Patient Days (excl. MHRF)	21,703	18,727	2,976	15.9%	21,857
23	1,982	2,010	(28)	-1.4%	1,816	Medicare Patient Days (excl. MHRF)	8,182	8,073	109	1.4%	7,984
24	2,020	2,224	(204)	-9.2%	1,209	Other Patient Days (excl. MHRF)	8,514	8,934	(420)	-4.7%	8,172
25	9,594	8,897	697	7.8%	9,285	Total Patient Days(excl. MHRF)	38,399	35,734	2,665	7.5%	38,013
27	6,055	5,262	793	15.1%	7,016	Medi-Cal Patient Days	23,190	21,050	2,140	10.2%	24,528
28	1,982	2,063	(81)	-3.9%	1,847	Medicare Patient Days	8,182	8,253	(71)	-0.9%	8,077
29	5,867	5,911	(44)	-0.7%	4,629	Other Patient Days	24,157	23,648	509	2.2%	21,943
30	13,904	13,236	668	5.0%	13,492	Total Patient Days	55,529	52,951	2,578	4.9%	54,548
31	20,012	18,610	1,402	7.5%	19,185	Adjusted Patient Days	77,258	74,275	2,983	4.0%	77,063
33	83.5%	79.5%	4.0%	5.0%	81.0%	% Occupancy (available beds)	84.1%	80.3%	3.8%	4.7%	82.5%
KEY OPERATIONAL INDICATORS											
<u>Labor</u>											
38	2,384	2,380	(4)	-0.2%	2,306	FTEs - Productive	2,385	2,380	(5)	-0.2%	2,294
39	276	329	53	16.2%	292	FTEs - Non-Productive	291	329	38	11.6%	302
40	2,659	2,709	50	1.8%	2,598	Total FTEs - SFGH Only	2,676	2,709	33	1.2%	2,596
41	334	334	0	n/a	334	UC Non-Academic FTEs	334	334	0	n/a	334
42	2,993	3,043	50	1.6%	2,932	Grand Total FTEs Incl. UC	3,010	3,043	33	1.1%	2,930
43	4.6	5.1	0.5	9.8%	4.7	FTEs Per AOB (incl. UC)	4.8	5.1	0.3	6.4%	4.7
44	\$ 62,320	\$ 60,126	(\$2,194)	-3.6%	\$58,867	Average Labor Cost per SFGH FTE	\$ 62,242	\$60,126	(\$2,116)	-3.5%	\$ 58,641
45	24.0%	24.3%	0.3%	1.2%	24.8%	Fringe Benefits as % of Salary	24.0%	24.0%	0.0%	n/a	23.5%
46	0	227	(227)	-100.0%	344	Vacancy positions (as of the last PPE)	0	227	(227)	-100.0%	344
<u>Revenues</u>											
49	\$ 1,229	\$ 1,313	(\$84)	-6.4%	\$1,304	Oper. Rev. Per Adjusted Patient Day (incl. MHRF)	\$ 1,290	\$1,314	(\$24)	-1.8%	\$1,285
50	\$ 616	\$ 645	(\$29)	-4.5%	\$650	Oper. Rev. (excl. SB855/1255/GME)/APD	\$ 655	\$645	\$10	1.6%	\$634
51	\$ 12,582	\$ 12,075	\$507	4.2%	\$12,190	Oper. Rev. Per Adjusted Discharge	\$ 12,913	\$12,094	\$819	6.8%	\$11,696
52	\$ 6,308	\$ 5,929	\$379	6.4%	\$6,077	Oper. Rev. (excl. SB855/1255/GME)/Adj. Discharge	\$ 6,554	\$5,933	\$621	10.5%	\$5,772
<u>Expenses</u>											
55	\$ 2,153	\$ 2,067	(\$86)	-4.2%	\$1,871	Operating Exp. Per Adjusted Pt. Day	\$ 2,068	\$2,069	\$1	0.0%	\$1,901
56	\$ 1,793	\$ 1,628	(\$165)	-10.1%	\$1,444	Operating Exp.(excl. IGT)/Adj. Pt. Day	\$ 1,657	\$1,628	(\$29)	-1.8%	\$1,477
57	\$ 22,034	\$ 19,019	(\$3,015)	-15.9%	\$17,489	Operating Exp. Per Adj. Discharge	\$ 20,708	\$19,038	(\$1,670)	-8.8%	\$17,302
58	\$ 18,358	\$ 14,973	(\$3,385)	-22.6%	\$13,500	Operating Exp.(excl. IGT)/Adj. Discharge	\$ 16,594	\$14,982	(\$1,612)	-10.8%	\$13,436
59	34.1%	32.9%	-1.2%	-3.6%	30.8%	Supply Expense as % of Net Pt. Revenue	31.1%	32.7%	1.6%	4.9%	32.7%
61	84	80	(4)	-5.0%	117	Days Revenue in Accounts Receivable	84	80	(4)	-5.0%	117

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President

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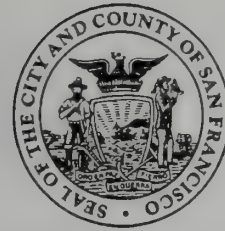
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Commissioner

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CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

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PUBLIC NOTICE

JOINT CONFERENCE COMMITTEE FOR THE SAN FRANCISCO GENERAL HOSPITAL COMMITTEE MEETING

DOCUMENTS DEPT

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The Joint Conference Committee for the San Francisco General Hospital meeting originally scheduled for Tuesday, January 8, has been rescheduled for Tuesday, January 15, 2002.

For information call the Health Commission Office at 554-2666

Posted December 20, 2001

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Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

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David J. Sanchez, Jr., Ph.D.
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Commissioner

HEALTH COMMISSION
CITY AND COUNTY OF SAN FRANCISCO
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AGENDA

**JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING**

Tuesday, January 15, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

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Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

- 1) **CALL TO ORDER**
- 2) **PROPOSED ACTION:** **APPROVAL OF MINUTES OF DECEMBER 11, 2001**
**Minutes of December 11, 2001*
- 3) **FOR DISCUSSION:** **HOSPITAL HEALTHCARE UPDATE**
(Activities and operations of SFGH)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) **FOR DISCUSSION:** **PATIENT CARE REPORT**
(Sue Currin, RN, Chief Nursing Office)
**Report*
- 5) **FOR DISCUSSION:** **FINANCE REPORT - STATEMENT OF REVENUES AND EXPENDITURES**
(Gregg Sass, CHN Chief Financial Officer)
**Report*

- 6) **FOR DISCUSSION:** **PBM UPDATE**
(Sharon Kotabe, CHN Director of Pharmaceutical Services)
**Update*
- 7) **FOR DISCUSSION:** **FISCAL YEAR 2002-03 CAPITAL PROJECTS UPDATE**
(John Kanaley, Director of Support Services)
**Update*
- 8) **PUBLIC COMMENT****
- 9) **CLOSED SESSION**

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **APPROVAL OF CLOSED SESSION MINUTES OF DECEMBER 11, 2001**

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE**

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: **CONSIDERATION OF CREDENTIALING MATTERS**
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION: **MEDICAL STAFF REPORT**
J. Renee Navarro, M.D., Chief of Staff

D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)(2) and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

10) **ADJOURNMENT**

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

* Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines *#9 San Bruno*, *#9X San Bruno Express*, *#19 Polk* (stops 2 blocks away), *#33 Haight Ashbury*, and *#48 Quintara*. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at:
www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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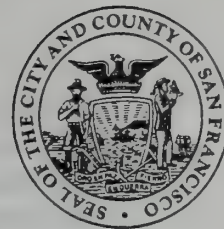
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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, January 15, 2002
3:45 p.m.

1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

1) CALL TO ORDER

The San Francisco General Hospital Joint Conference Committee was called to order by Commissioner Lee Ann Monfredini at 3:45 p.m.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

Staff: Wahid Choudhury, Sue Currin, Myra Garcia, Mozettia Henley,
Fred Hom, Philip Hopewell, M.D., John Kanaley, Sharon Kotabe,
John Luce, M.D., Beth Maloney, Alison Moed, Kathleen Murphy,
J. Renee Navarro, M.D., Gene O'Connell, Roland Pickens, Gregg
Sass, Hiroshi Tokubo, Chris Wachsmuth, Connie Young

2) APPROVAL OF MINUTES OF DECEMBER 11, 2001

Action Taken: The Committee approved the minutes of the December 11, 2001
San Francisco General Hospital Joint Conference Committee.

3) HOSPITAL HEALTHCARE UPDATE

Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center,
presented the Hospital Healthcare Update.

Improving Patient Flow and Care through Increase in Funded Beds

SFGH thanked the Health Commission for their support in increasing the number of funded beds at San Francisco General Hospital Medical Center. San Francisco General Hospital Medical Center has been experiencing an increase in census, which consequently impacts the diversion rates as well as ability to move patients efficiently throughout the system. The increase in the number of staffed beds will increase SFGHMC's ability to improve patient flow and care. Sue Currin, Chief Nursing Officer, will provide more details within her *Patient Care Services Report* on how the additional funded beds will assist the overall inpatient area. Thank you again for your support.

AB430 Funds Restored

SFGH announced that the AB 430 funds have been restored. In December 2001, Governor Davis had placed a hold on these funds until he convened the legislature in January to discuss the State's fiscal health. As discussed in the October 2001 JCC-SFGH, the bill provides for one-time funding for designated trauma centers in the State to provide trauma care. The bill also allocated funding for development of trauma plans in counties with trauma systems of care and for trauma data collection by county EMS Agencies. SFGH is now working closely with the EMS Agency to prepare to receive the approximately \$920,000 that SFGH can expect to receive within the next two months to support trauma patient care.

Appointment of New Controller

SFGH announced the selection of a new controller for San Francisco General Hospital Medical Center. Wahid Choudhury comes to us with a rich experience in Finance and Accounting, including a CPA and two MBAs in Finance and Accounting. Prior to joining SFGHMC, he served as the Director of Finance for Mills Peninsula Health Services in Burlingame, California. Mr. Choudhury began his new position January 14th.

4) PATIENT CARE REPORT

Sue Currin, RN, Chief Nursing Office, presented the Patient Care Report (Attachment A).

Commissioners' Comments

- Commissioner Monfredini asked if utilization of the Emergency Department by inebriates has been looked at recently, in light of the interest in this issue by members of the Board of Supervisors. Chris Wachsmuth replied that San Francisco General Hospital did a study with other hospitals looking at inebriate utilization, and found that a very small number of patients were brought to the Emergency Department solely because they were inebriated.

5) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES

Gregg Sass, CHN Chief Financial Officer, presented the Finance Report (Attachment B).

6) PBM UPDATE

Sharon Kotabe, CHN Director of Pharmaceutical Services, presented the PBM Update. When the Health Commission approved the PMB contract in October 2000, the Department committed to a one-year evaluation to determine if the goals of the contract had been met. The major goals of the PBM contract were:

- To improve access to prescription services of indigent CHN patients
- To improve prescription services for indigent CHN patients

The PBM dramatically increased the number of pharmacies from which indigent patients could get their prescriptions, and patients did take advantage of this by getting prescriptions filled at locations throughout the city. This implies easier access. In addition, total prescription volume increased five percent in the last six months of the contract.

With regard to improved service, Ms. Kotabe said that the PBM contract provided seven days a week, 24 hour per day services, plus free delivery at some pharmacies. The wait time was decreased, with approximately 90 percent of the time patients get their prescriptions filled in under an hour and the majority waiting no more than 30 minutes. The system has linguistic capability for 18 different languages. Ms. Kotabe added that the contractor and CHN recently completed the electronic interface that allows transfer of prescription data from the network pharmacies directly to the patient's electronic medical record, and implemented systems for real-time transfer of eligibility information.

Ms. Kotabe presented client satisfaction data and an update on the activities of the PBM Oversight Committee. She then discussed fiscal information and said that, on average, nationwide pharmaceutical costs have risen 10 to 15 percent since 1999, and SFGH's increase is consistent with that average. Pharmaceutical Services has implemented a variety of programs to contain costs. Ms. Kotabe said that increased drug costs and increased volume have led to PBM expenses that were higher than originally projected. Ms. Kotabe said that the average cost per prescription through the PBM is \$50.97, and the average cost per prescription through the SFGH Outpatient Pharmacy is \$56.68.

Ms. Kotabe described the "next steps" that were being considered to deal with the cost and volume increases, including providing a 10-day supply of medication at discharge, limiting most prescriptions to a 30-day supply and various lobbying and legislative efforts.

7) FISCAL YEAR 2002-03 CAPITAL PROJECTS UPDATE

John Kanaley, Director of Support Services, presented the Fiscal Year 2002-2003 Capital Projects Update. Mr. Kanaley's presentation highlighted major funded projects in progress in the current year, the capital funding requests for the coming year and the challenges for DPH facilities. He also provided a complete list of funded and proposed projects.

Mr. Kanaley stated that the Department is overseeing approximately \$18 million in facility maintenance and capital project funds at DPH sites:

- \$8.3 million at San Francisco General Hospital
- \$6.9 million at Primary Care Centers
- \$2.6 million at Laguna Honda Hospital
- \$100,000 at Population Health/Mental Health
- \$200,000 at Community Health Network

One challenge facing DPH facilities is facility maintenance. The age of the buildings is a significant factor in the cost to maintain the sites. The use of buildings is limited by inefficient layouts and obsolete infrastructure. And the increasing backlog of deferred maintenance is more costly and less effective. Another challenge is the funding for capital and facilities maintenance. Recent budget increases will be curtailed—the capital budget allocation for FY 2002-2003 represents a \$5.4 million

reduction from last year's budget. In addition, facility maintenance budgets are below industry standards.

8) **PUBLIC COMMENT**

None.

9) **CLOSED SESSION**

A) **Public Comments on All Matters Pertaining to the Closed Session**

None.

B) **Vote on Whether to Hold a Closed Session**

Action Taken: The Committee voted to hold a Closed Session.

The Committee went into Closed Session at 5:00 p.m. Everyone present in Open Session was present in Closed Session, with the exception of Gregg Sass, Fred Hom, Sharon Kotabe and Wahid Choudhury.

C) **Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1**

APPROVAL OF CLOSED SESSION MINUTES OF DECEMBER 11, 2001

Action Taken: The Committee approved the December 11, 2001 Closed Session minutes.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

CONSIDERATION OF CREDENTIALING MATTERS

Action Taken: The Committee approved the January 2002 Credentials Report

MEDICAL STAFF REPORT

J. Renee Navarro, M.D., Chief of Staff

D) **Reconvene in Open Session**

The Committee came out of Closed Session at 5:10 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in Closed Session.

10) ADJOURNMENT

The meeting was adjourned at 5:10 p.m.

A handwritten signature in dark ink, appearing to read "Michele M. Olson", is written over a horizontal line.

Michele M. Olson
Executive Secretary to the Health Commission

Attachments (2)

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 1/15/02

Sue Currin, RN, MS, Chief Nursing Officer

1. ADDITION OF SNF/MED-SURG BEDS

UNIT	BED CAPACITY	2001 BUDEGTED BEDS	ACTUAL ADC YTD	NEW 2002 BUDGETED BEDS	TOTAL CHANGE
4A-SNF	30	20	*28.2	28	↑8
4B	32	Stepdown 21	Stepdown 16.3	***Stepdown 21	0
4D	34	29	28.3	30	↑1
5A	34	16	19.2	16	0
5C	30	23	27.8	28	↑5
5D	34	27	28.2	32	↑5
6A	33	19	21.6	20	↑1
7D	10	4	5.2	4	0
Totals	237	159	174.8 + **4 =178.8	179	↑20 SNF, Med-Surg, Stepdown Beds

SUMMARY OF BUDGETED BEDS BY AREA:

AREA	BED CAPACITY	2001 BUDEGTED BEDS	ACTUAL ADC YTD	2002 BUDGETED BEDS
SNF	30	20	*28.2	28
Med-Surg/Stepdown	207	139	150.4	151
Critical Care	30	21	19.6	21
Perinatal	45	25	28.9	25
Psychiatry	100	92	92.0	92
MHRF	152	140	139.2	140
TOTALS	564	437	459	457

* Includes 2 bed holds.

** ADC of Med-Surg patients waiting for beds in the ED/PACU is ~4. This ADC is in addition to the Unit summaries listed.

*** The overall number of Stepdown beds will be decreased to create additional Med-Surg beds. ~3 Stepdown beds may be re-located to another unit in order to add Med-Surg beds for the Traumatic Brain Injury and Cardiac patients requiring telemetry.

Critical Care, Stepdown, OR, and Med-Surg Training Programs are scheduled to begin January, 2002.

2. DIVERSION SUMMARY REPORT

See attached.

San Francisco General Hospital

Diversion Report

December 2001

Executive Summary

The Emergency Department [ED] recorded 38 episodes of diversion for 210 hours representing a rate of 28% in **December 2001**. This is a 1.0% increase in diversion since November 2001.

The 42 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from previous month
Total diversion	38	210	28%	1.0%
Trauma over-ride	4	5	0.6%	0.6%

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 166 patients were awaiting admission to in-patient beds [ICU-15, 4B/StepDown-74, MedSurg-77]. **In December of 2000, the ED was on diversion 22% of the month. Trauma Override was invoked 4% of the month in December 2000.**

Total diversion was recorded for 38 episodes, a total of 210 hours or a 28% rate for December 2001. While on Total Diversion the ED held 166 patients.

Trauma override was recorded for 4 episodes, a total of 5 hours or a 0.6% rate for December 2001. This is a 0.6% increase in trauma override from November 2001. While on Trauma override the ED held 14 patients awaiting inpatient beds.

San Francisco General Hospital
Emergency Department
December 2001
Total Diversion Summary

In December, the Emergency Department recorded 38 episodes of
Total Diversion for 210 hours, a percentage of 28% for the month.

Date	Length	Summary of Event
12/01/01	1740-2040 (3h)	29 patients in the ED Admits: 2-Floor Fast Track: Closed ED waiting room: 0 urgent patients
12/03/01	1745-0145 (8h)	17 patients in the ED Admits: 5-4B; 3-Floor Fast Track: Closed ED waiting room: 6 urgent patients
12/04/01	1540-1915 (3h 35m)	30 patients in the ED Admits: 2-4B; 3-Floor Fast Track: Open ED waiting room: 7 urgent patients
12/05/01	1810-2240 (4h 30m)	21 patients in the ED Admits: 1-4B; 3-Floor Fast Track: Closed ED waiting room: 5 urgent patients
12/06/01	0120-1650 (15h 30m)	48 patients in the ED Admits: 4-4B Fast Track: Open ED waiting room: 6 urgent patients
12/06/01	1825-2000 (1h 45m)	26 patients in the ED Admits: 1-ICU; 2-4B; 5-Floor Fast Track: Closed ED waiting room: 3 urgent patients
12/07/01	0130-0530 (4h)	30 patients in the ED Admits: 1-ICU; 3-4B Fast Track: Closed ED waiting room: 8 urgent patients
12/07/01	1225-0120 (11h 55m)	46 patients in the ED Admits: 6-4B; 3-Floor Fast Track: Open ED waiting room: 0 urgent patients
12/08/01	1420-2140 (7h 20m)	31 patients in the ED Admits: 3-4B; 2-Floor Fast Track: Open ED waiting room: 8 urgent patients
12/09/01	0425-0955 (5h 30m)	27 patients in the ED Admits: 2-4B; 4-Floor Fast Track: Closed ED waiting room: 0 urgent patients
12/09/01	1755-2155 (4h)	25 patients in the ED Admits: 0 Fast Track: Closed ED waiting room: 5 urgent patients
12/10/01	1435-1852 (4h 17m)	29 patients in the ED Admits: 2-4B Fast Track: Open ED waiting room: 8 urgent patients

12/10/01	2045-0045 (4h)	34 patients in the ED Admits: 3-4B; 4-Floor Fast Track: Closed ED waiting room: 10 urgent patients
12/11/01	1215-1840 (6h 25m)	37 patients in the ED Admits: 1-ICU; 4-4B Fast Track: Open ED waiting room: 2 urgent patients
12/12/01	1405-1755 (3h 50m)	33 patients in the ED Admits: 1-ICU; 1-Floor Fast Track: Open ED waiting room: 4 urgent patients
12/13/01	0145-0630 (4h 45m)	30 patients in the ED Admits: 1-4B Fast Track: Closed ED waiting room: 0 urgent patients
12/13/01	1655-0000 (7h 5m)	34 patients in the ED Admits: 1-ICU; 4-4B; 2-Floor Fast Track: Closed ED waiting room: 4 urgent patients
12/14/01	1915-2300 (3h 45m)	22 patients in the ED Admits: 2-ICU; 1-4B; 7-Floor Fast Track: Closed ED waiting room: 12 urgent patients
12/15/01	1810-2200 (3h 50m)	27 patients in the ED Admits: 0 Fast Track: Closed ED waiting room: 0 urgent patients
12/16/01	0500-0750 (2h 50m)	39 patients in the ED Admits: 0 Fast Track: Closed ED waiting room: 0 urgent patients
12/16/01	1645-1900 (2h 15m)	30 patients in the ED Admits: 1-ICU; 2-4B; 2-Floor Fast Track: Closed ED waiting room: 0 urgent patients
12/17/01	0955-1400 (4h 5m)	25 patients in the ED Admits: 1-4B; 1-Floor Fast Track: Open ED waiting room: 1 urgent patient
12/17/01	1700-2250 (5h 50m)	34 patients in the ED Admits: 0 Fast Track: Closed ED waiting room: 7 urgent patients
12/18/01	1330-1537 (2h 7m)	37 patients in the ED Admits: 2-4B; 2-Floor Fast Track: Open ED waiting room: 0 urgent patients
12/18/01	1800-0010 (6h 10m)	28 patients in the ED Admits: 3-Floor Fast Track: Closed ED waiting room: 9 urgent patients
12/19/01	1540-0210 (10h 30m)	28 patients in the ED Admits: 3-4B; 5-Floor Fast Track: Closed ED waiting room: 5 urgent patients
12/20/01	1942-0300 (7h 18m)	32 patients in the ED Admits: 3-ICU; 3-4B; 3-Floor Fast Track: Closed ED waiting room: 6 urgent patients
12/21/01	1600-1755 (1h 55m)	32 patients in the ED Admits: 4-4B; 2-Floor Fast Track: Open ED waiting room: 7 urgent patients

12/22/01	1645-2010 (3h 25m)	33 patients in the ED Admits: 1-ICU; 1-Floor Fast Track: Open ED waiting room: 2 urgent patients
12/23/01	0430-0930 (4h 30m)	28 patients in the ED Admits: 1-ICU; 3-4B; 8-Floor Fast Track: Closed ED waiting room: 4 urgent patients
12/23/01	1355-1525 (1h 30m)	32 patients in the ED Admits: 1-ICU; 2-4B Fast Track: Open ED waiting room: 0 urgent patients
12/24/01	2110-0010 (3h)	41 patients in the ED Admits: 1-ICU; 3-4B Fast Track: Open ED waiting room: 6 urgent patients
12/26/01	0045-2210 (11h 25m)	38 patients in the ED Admits: 1-4B; 3-Floor Fast Track: Open ED waiting room: 3 urgent patients
12/27/01	1717-0002 (6h 45m)	27 patients in the ED Admits: 2-4B; 4-Floor Fast Track: Open ED waiting room: 0 urgent patients
12/28/01	1330-2110 (7h 40m)	32 patients in the ED Admits: 3-Floor Fast Track: Closed ED waiting room: 2 urgent patients
12/30/01	0130-0315 (1h 45m)	20 patients in the ED Admits: 0 Fast Track: Closed ED waiting room: 0 urgent patients
12/30/01	1653-0500 (12h 7m)	31 patients in the ED Admits: 4-4B Fast Track: Closed ED waiting room: 0 urgent patients
12/31/01	1210-1930 (7h 20m)	33 patients in the ED Admits: 1-4B; 1-Floor Fast Track: Open ED waiting room: 7 urgent patients

San Francisco General Hospital
Emergency Department
December 2001
Trauma Override Summary

The Emergency Department recorded 4 episodes of Trauma Override for 5 hours and 40 min, a percentage of .6% for the month of December.

Date	Length	Summary of Event
12/07/01	1400-1645 (2h 45m)	911-1 912-2 910-0
12/12/01	1755-1830 (35m)	911-0 912-2 910-1
12/31/01	1410-1610 (2h)	911-1 912-0 910-0
12/31/01	1640-1700 (20m)	911-1 912-2 910-0

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/2002

Month Ending: DEC 31, 2001

(In Thousands of Dollars)

MONTHLY						ANNUAL					
Fav/(Unfav)						Fav/(Unfav)					
Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual	
GROSS PATIENT REVENUE:						GROSS PATIENT REVENUE:					
1	14,974	14,542	432	3.0%	14,109	Inpatient Medi-Cal Revenue	182,284	171,999	10,285	6.0%	153,288
2	4,123	4,820	(697)	-14.5%	3,719	Outpatient Medi-Cal Revenue	50,042	56,751	(6,709)	-11.8%	50,578
3	6,545	5,099	1,446	28.4%	5,148	Inpatient Medicare Revenue	65,785	60,321	5,464	9.1%	63,264
4	1,783	1,897	(114)	-6.0%	1,656	Outpatient Medicare Revenue	23,659	22,337	1,322	5.9%	23,428
5	8,952	8,760	192	2.2%	8,229	Inpatient Other Revenue	126,332	103,635	22,697	21.9%	117,606
6	5,765	4,787	978	20.4%	4,459	Outpatient Other Revenue	72,097	56,365	15,732	27.9%	63,963
7											
8	<u>42,142</u>	<u>39,905</u>	<u>2,237</u>	<u>5.6%</u>	<u>37,320</u>	TOTAL PATIENT SERVICE REVENUE	<u>520,199</u>	<u>471,408</u>	<u>48,791</u>	<u>10.4%</u>	<u>472,127</u>
9											
10						REVENUE DEDUCTIONS:					
11	4,917	6,610	1,693	25.6%	5,276	Charity Care	64,775	76,680	11,905	15.5%	80,219
12	14,973	14,833	(140)	-0.9%	15,825	Provision for Medi-Cal Adjustments	185,322	175,229	(10,093)	-5.8%	161,290
13	3,958	2,517	(1,441)	-57.3%	2,443	Provision for Medicare Adjustments	44,419	29,737	(14,682)	-49.4%	43,021
14	5,791	3,984	(1,807)	-45.4%	4,557	Provision for Other Adjustments	73,543	48,463	(25,080)	-51.8%	54,599
15	1,875	2,074	199	9.6%	1,917	Provision for Bad Debt	22,500	24,500	2,000	8.2%	19,022
16	<u>31,514</u>	<u>30,018</u>	<u>(1,496)</u>	<u>-5.0%</u>	<u>30,018</u>	TOTAL REVENUE DEDUCTIONS	<u>390,559</u>	<u>354,609</u>	<u>(35,950)</u>	<u>-10.1%</u>	<u>358,151</u>
17											
18	<u>10,628</u>	<u>9,887</u>	<u>741</u>	<u>7.5%</u>	<u>7,302</u>	NET PATIENT SERVICE REVENUE	<u>129,640</u>	<u>116,799</u>	<u>12,841</u>	<u>11.0%</u>	<u>113,976</u>
19											
20						OTHER OPERATING REVENUE:					
21	710	710	0	n/a	728	Capitation/Managed Care Settlement	8,519	8,519	0	n/a	9,537
22	421	421	0	n/a	388	Short Doyle	5,054	5,054	0	n/a	4,654
23	0	0	0	n/a	0	MHRF Funding	0	0	0	n/a	0
24	10,515	10,515	0	n/a	10,626	SB855	126,183	126,183	0	n/a	104,112
25	1,642	1,808	(166)	-9.2%	1,808	SB1255	19,700	21,700	(2,000)	-9.2%	22,000
26	108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300
27	594	660	(66)	-10.0%	830	Revenue from Other City Departments	7,132	7,924	(792)	-10.0%	9,394
28	0	0	0	n/a	448	Prior Year Settlement	362	0	362	n/a	(3,679)
29	333	494	(161)	-32.6%	292	MAA & Other Net Patient Revenue	4,000	4,381	(381)	-8.7%	4,085
30	<u>14,323</u>	<u>14,716</u>	<u>(393)</u>	<u>-2.7%</u>	<u>15,228</u>	TOTAL OTHER OPERATING REVENUE	<u>172,250</u>	<u>175,061</u>	<u>(2,811)</u>	<u>-1.6%</u>	<u>151,403</u>
31											
32	<u>24,951</u>	<u>24,603</u>	<u>348</u>	<u>1.4%</u>	<u>22,530</u>	TOTAL OPERATING REVENUE	<u>301,890</u>	<u>291,860</u>	<u>10,030</u>	<u>3.4%</u>	<u>265,379</u>
33											
34						OPERATING EXPENSES:					
35	13,601	13,667	66	0.5%	12,643	Personnel Services	167,789	162,986	(4,803)	-2.9%	154,275
36	3,261	3,290	29	0.9%	2,959	Mandatory Fringe Benefits	40,231	39,079	(1,152)	-2.9%	37,027
37	8,737	8,487	(250)	-2.9%	8,428	Contractual Services	103,300	100,300	(3,000)	-3.0%	96,497
38	2,100	2,100	0	n/a	2,148	Materials and Supplies (excl. Pharm.)	25,205	25,205	0	n/a	26,664
39	1,167	1,167	0	n/a	1,100	Pharmaceuticals	14,000	14,000	0	n/a	12,710
40	630	630	0	n/a	382	Facilities Maintenance & Capital Outlay	7,562	7,562	0	n/a	5,906
41	1,459	1,455	(4)	-0.3%	1,016	Services of Other Departments	17,504	17,461	(43)	-0.2%	16,021
42	(99)	(110)	(11)	-10.0%	(106)	Expenditure Recovery	(1,187)	(1,319)	(132)	-10.0%	(639)
43	7,935	8,185	250	3.1%	8,185	Operating Transfer Out	95,225	98,225	3,000	3.1%	67,996
44	427	427	0	n/a	187	Intrafund Transfer	5,129	5,129	0	n/a	2,248
45	0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0
46	635	635	0	n/a	428	Continuing Projects	7,618	7,618	0	n/a	5,131
47	<u>39,853</u>	<u>39,933</u>	<u>80</u>	<u>0.2%</u>	<u>37,370</u>	TOTAL OPERATING EXPENSES	<u>482,376</u>	<u>476,246</u>	<u>(6,130)</u>	<u>-1.3%</u>	<u>423,836</u>
48											
49	<u>(14,902)</u>	<u>(15,330)</u>	<u>428</u>	<u>2.8%</u>	<u>(14,840)</u>	OPERATING INCOME/(LOSS)	<u>(180,486)</u>	<u>(184,386)</u>	<u>3,900</u>	<u>2.1%</u>	<u>(158,457)</u>
50											
51						NON-OPERATING REVENUE:					
52	8,020	8,020	0	n/a	6,630	General Fund	96,245	96,245	0	n/a	81,090
53	5,093	5,093	0	n/a	5,093	Realignment	61,113	61,113	0	n/a	61,113
54	285	285	0	n/a	317	Prop 99	3,423	3,423	0	n/a	3,807
55	487	487	0	n/a	247	Transfer In and Project-Related	5,846	5,846	0	n/a	2,723
56	1,207	1,207	0	n/a	845	Carryforward	14,482	14,482	0	n/a	10,074
57	73	73	0	n/a	73	Cafeteria	877	877	0	n/a	758
58	200	200	0	n/a	214	Miscellaneous	2,400	2,400	0	n/a	2,439
59	<u>15,365</u>	<u>15,365</u>	<u>0</u>	<u>n/a</u>	<u>13,419</u>	TOTAL NON-OPERATING REVENUE	<u>184,386</u>	<u>184,386</u>	<u>0</u>	<u>n/a</u>	<u>162,004</u>
60											
61	<u>463</u>	<u>35</u>	<u>428</u>	<u>1222.9%</u>	<u>(1,421)</u>	NET INCOME/(LOSS)	<u>3,900</u>	<u>0</u>	<u>3,900</u>	<u>n/a</u>	<u>3,547</u>

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/2002
Month Ending: DEC 31, 2001

CURRENT MONTH						YEAR-TO-DATE					
Actual	Budget	Variance	% Var	Prior Year		Actual	Budget	Variance	% Var	Prior Year	
<u>KEY VOLUME INDICATORS</u>											
<u>Discharges (incl. MHRF)</u>											
1,435	1,442	(7)	-0.5%	1,581	Discharges (incl. MHRF)	8,560	8,573	(13)	-0.2%	9,046	
1,985	2,026	(41)	-2.0%	2,147	Adjusted Discharges (incl. MHRF)	11,902	12,039	(137)	-1.1%	12,722	
<u>Average Daily Census</u>											
183	176	7	4.0%	184	Acute Med/Surg ADC	192	177	15	8.2%	191	
92	92	0	n/a	91	Psych ADC	93	92	1	0.7%	92	
28	20	8	38.0%	24	Skilled Nursing ADC	26	20	6	29.5%	22	
303	288	15	5.1%	299	Total ADC excl. MHRF	310	289	21	7.3%	305	
139	140	(1)	-0.6%	138	MHRF ADC	139	140	(1)	-0.6%	135	
442	428	14	3.2%	437	Total Adult ADC	449	429	20	4.7%	440	
7	7	0	n/a	7	Nursery ADC	7	7	0	n/a	7	
6.6	6.4	(0.2)	-3.1%	5.9	Average Length of Stay (excl. MHRF)	6.8	5.9	(0.9)	-15.3%	6.3	
1.283	1.295	(0.012)	-0.9%	1.227	Medicare Case Mix Index*	1.283	1.295	(0.012)	-0.9%	1.227	
<u>Payor Mix (Gross Revenue)</u>											
45.3%	48.5%	-3.2%	-6.6%	47.8%	Medi-Cal	44.7%	48.5%	-3.8%	-7.9%	47.2%	
19.8%	17.5%	2.3%	12.9%	18.2%	Medicare	17.2%	17.5%	-0.3%	-1.8%	17.6%	
34.9%	34.0%	0.9%	2.7%	34.0%	Other	38.1%	34.0%	4.1%	12.2%	35.2%	
100.0%	100.0%	0.0%	n/a	100.0%	Total	100.0%	100.0%	0.0%	0.0%	100.0%	
<u>Patient Days</u>											
5,162	4,679	483	10.3%	5,063	Medi-Cal Patient Days (excl. MHRF)	32,138	27,840	4,298	15.4%	31,553	
2,448	2,017	431	21.4%	2,161	Medicare Patient Days (excl. MHRF)	12,670	12,001	669	5.6%	12,091	
1,771	2,232	(461)	-20.7%	2,046	Other Patient Days (excl. MHRF)	12,286	13,281	(995)	-7.5%	12,517	
9,381	8,928	453	5.1%	9,270	Total Patient Days(excl. MHRF)	57,094	53,122	3,972	7.5%	56,161	
5,462	5,275	187	3.5%	5,691	Medi-Cal Patient Days	34,317	31,358	2,959	9.4%	35,512	
2,448	2,068	380	18.4%	2,235	Medicare Patient Days	12,670	12,294	376	3.1%	12,313	
5,787	5,925	(138)	-2.3%	5,627	Other Patient Days	35,725	35,227	498	1.4%	33,248	
13,697	13,268	429	3.2%	13,553	Total Patient Days	82,712	78,879	3,833	4.9%	81,073	
18,943	18,642	301	1.6%	18,402	Adjusted Patient Days	114,986	110,778	4,208	3.8%	114,047	
82.3%	79.7%	2.6%	3.3%	81.4%	% Occupancy (available beds)	83.6%	79.9%	3.7%	4.6%	81.9%	
<u>KEY OPERATIONAL INDICATORS</u>											
<u>Labor</u>											
2,326.8	2,380.0	53.2	2.2%	2,203.0	FTEs - Productive	2,349.9	2,380.0	30.1	1.3%	2,252.2	
346.5	329.0	(17.5)	-5.3%	377.0	FTEs - Non-Productive	344.0	329.0	(15.0)	-4.6%	352.2	
2,673.3	2,709.0	35.7	1.3%	2,580.0	Total FTEs - SFGH Only	2,693.9	2,709.0	15.1	0.6%	2,604.3	
334	334	0	n/a	334	UC Non-Academic FTEs	334	334	0	n/a	334	
3,007	3,043	36	1.2%	2,914	Grand Total FTEs Incl. UC	3,028	3,043	15	0.5%	2,938	
4.9	5.1	0.2	3.9%	4.9	FTEs Per AOB (incl. UC)	4.8	5.1	0.3	5.2%	4.7	
\$ 62,320	\$ 60,126	(\$2,194)	-3.6%	\$58,459	Average Labor Cost per SFGH FTE	\$ 61,998	\$60,126	(\$1,872)	-3.1%	\$ 58,526	
24.0%	24.1%	0.1%	0.4%	23.4%	Fringe Benefits as % of Salary	24.0%	24.0%	0.0%	n/a	23.7%	
<u>Revenues</u>											
\$ 1,317	\$ 1,311	\$6	0.5%	\$1,263	Oper. Rev. Per Adjusted Patient Day (incl. MHRF)	\$ 1,302	\$1,319	(\$17)	-1.3%	\$1,314	
\$ 670	\$ 644	\$26	4.0%	\$581	Oper. Rev. (excl. S8855/1255/GME)/APD	\$ 662	\$645	\$17	2.6%	\$654	
\$ 12,570	\$ 12,065	\$505	4.2%	\$10,822	Oper. Rev. Per Adjusted Discharge	\$ 12,577	\$12,135	\$442	3.6%	\$11,780	
\$ 6,391	\$ 5,929	\$462	7.8%	\$4,980	Oper. Rev. (excl. S8855/1255/GME)/Adj. Discharge	\$ 6,394	\$5,939	\$455	7.7%	\$5,864	
<u>Expenses</u>											
\$ 2,104	\$ 2,070	(\$34)	-1.6%	\$2,031	Operating Exp. Per Adjusted Pt. Day	\$ 2,086	\$2,081	(\$5)	-0.2%	\$1,973	
\$ 1,685	\$ 1,631	(\$54)	-3.3%	\$1,586	Operating Exp.(excl. IGT)/Adj. Pt. Day	\$ 1,672	\$1,638	(\$34)	-2.1%	\$1,542	
\$ 20,078	\$ 19,049	(\$1,029)	-5.4%	\$17,406	Operating Exp. Per Adj. Discharge	\$ 20,150	\$19,152	(\$998)	-5.2%	\$17,688	
\$ 16,080	\$ 15,009	(\$1,071)	-7.1%	\$13,593	Operating Exp.(excl. IGT)/Adj. Discharge	\$ 16,149	\$15,073	(\$1,076)	-7.1%	\$13,827	
30.7%	32.9%	2.2%	6.7%	44.5%	Supply Expense as % of Net Pt. Revenue	30.9%	32.8%	1.9%	5.8%	34.8%	
90	80	(10)	-12.5%	117	Days Revenue in Accounts Receivable	90	80	(10)	-12.5%	117	

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

Edward A. Chow, M.D.
President

Roma P. Guy, M.S.W.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
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Harrison Parker, Sr., D.D.S.
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David J. Sánchez, Jr., Ph.D.
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John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

Tel. (415) 554-2666
FAX (415) 554-2665

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, February 12, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

02-08-02A09:47 RCVD

- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF JANUARY 15, 2002
*Minutes of January 15, 2002
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGH)
(Gene Marie O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
*Report
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, R.N., Chief Nursing Office)
*Report
- 5) FOR DISCUSSION: FINANCE REPORT - STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
*Report

6) FOR ACTION: CONSIDERATION AND APPROVAL OF THE MEDICAL STAFF BYLAWS

(J. Renee Navarro, M.D., Chief of Staff)

**Bylaws*

7) PUBLIC COMMENT**

8) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

B) Vote on Whether to Hold a Closed Session

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: APPROVAL OF CLOSED SESSION MINUTES OF JANUARY 15, 2002

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM

Hiroshi Tokubo, CHN Director, QM

Alison Moed, Director of Risk Management

FOR ACTION: CONSIDERATION OF CREDENTIALING MATTERS
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION: MEDICAL STAFF REPORT
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION: JCAHO ACTIVITIES UPDATE
Cathy Chou, M.P.A., JCAHO Coordinator

D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)

2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

10) ADJOURNMENT

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

* Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Plant Services Department at 206-8550 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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2/02
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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, February 12, 2002
3:45 p.m.

1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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1) CALL TO ORDER

The meeting of the San Francisco General Hospital Joint Conference Committee was called to order by Commissioner John I. Umekubo, M.D., at 3:45 p.m.

Present: Commissioner John I. Umekubo, M.D.

Absent: Commissioner Lee Ann Monfredini

Staff: Cathy Chou, Wahid Choudhury, Yuhum Digdigian, Myra Garcia, Mozettia Henley, John Luce, M.D., Beth Maloney, Alison Moed, Kathy Murphy, Renee Navarro, M.D., Gene O'Connell, Roland Pickens, Gregg Sass, Hiroshi Tokubo, Chris Wachsmuth.

2) APPROVAL OF MINUTES OF JANUARY 15, 2002

Action Taken: The Committee approved the minutes of the January 15, 2002 meeting.

3) HOSPITAL HEALTHCARE UPDATE

Gene Marie O'Connell, Executive Administrator, San Francisco General Hospital Medical Center, presented the Hospital Healthcare Update.

Program Updates

Closure of the UCSF Renal Center

Several months ago, it was reported to the JCC-SFGH that the University of California at San Francisco (UCSF) had informed San Francisco General Hospital of their plans to close the UCSF Renal Center located on-site due to ongoing financial losses over the past years. UCSF Renal Center provides chronic outpatient dialysis to SFGH/CHN patients and is a service that continues to be in high demand. SFGH Administration has been meeting with the UCSF Department of Medicine leadership to develop plans for ensuring the provision of outpatient dialysis services to SFGH and CHN patients. This collaborative planning process is critical due to the limited supply of available outpatient dialysis placements. Current plans are as follows:

1. UCSF Department of Medicine will maintain the currently available acute in-patient dialysis unit at SFGH, either on 5C, or possibly moving to 4B.
2. In surveying the availability of outpatient dialysis resources in the community, UCSF Department of Medicine has identified an existing for-profit outpatient dialysis provider that is willing to accept and provide services to the current 56 SFGH/CHN chronic outpatient dialysis patients. This provider currently has 12 outpatient dialysis chairs available at its nearby Potrero Hill location, which would support the SFGH/CHN population. In addition, the provider has two other locations in San Francisco which SFGH/CHN patients will be able to access. This entity has also indicated its desire to hire the existing UCSF employees who work in the UCSF Renal Center at SFGH.

SFGH will continue to update the JCC-SFGH on the provision of outpatient dialysis, as SFGH Administration and the UCSF Department of Medicine at San Francisco General Hospital progress in their planning and implementation activities.

Mammo Van

SFGH Radiology, DPH Patient Navigators and UCSF Mammo Van staff have been meeting and planning implementation of on-site location of the UCSF Mammo Van at SFGH, in order to alleviate the current 126 day back log. The Van will be located in parking lot A, and is expected to begin operations on March 4. The Van will operate at SFGH Monday - Friday 8:00 a.m. – 5:00 p.m. While based at SFGH, the Van will also be providing services to the community-based Health Center patients, in addition to providing services to the patients on the SFGH waiting list. Once the SFGH backlog is cleared, the Van will begin making routine visits to the various Health Centers.

An update will be provided to the JCC-SFGH once the van has begun providing services.

SFGHMC Plan to Eliminate or Substantially Reduce Medication-related Errors (SB 1875)

The 1999-2000 California Legislature enacted SB 1875, partially in response to the November 1999 Institute of Medicine's (IOM) report, "To Err is Human: Building a Safer Health System", which indicated that sizeable numbers of Americans were harmed each year as a result of medical errors. This legislation added Chapter 2.05 to the Health and Safety Code, and requires as a condition of licensure that all general acute care hospitals, surgical clinics and special hospitals adopt a formal plan to eliminate or substantially reduce medication-related errors. Guiding principles for development of facility specific plans were announced by the Department of Health Services (DHS) in November 2001, and specified that technology implementation be part of the plan. The deadline for submission to DHS of individual facility plans was January 1, 2002, and the deadline for implementation of the plan is January 1, 2005. SFGHMC submitted its plan to DHS on December 26, 2001.

Each step in the medication use process (prescribing, order communication, labeling, compounding, dispensing, distribution, administration, education) was addressed by the SFGHMC plan. High priority and focus were placed on two key strategies for improvement to achieve greater patient safety. These two key strategies are implementation of a computerized physician order entry (CPOE) system, and fostering a blame-free culture with respect to medication error reporting. CPOE will be implemented by January 2003, and a blame-free culture achieved by January 2005.

Methadone Van Update

Substance Abuse Services (SAS) is on schedule to initiate the two methadone vans in the late Spring 2002. The methadone mobile vans would be stationed at San Francisco General Hospital Medical Center and Laguna Honda Hospital. The implementation is dependent on the granting of licensure from both the State of California and the Federal Drug Administration (FDA), as well as the completion of the construction of the vans. Currently, one van has been constructed and delivered. The remaining van is still under construction.

In anticipation of receiving licensure in April 2002, SAS is proceeding with recruitment of van staff so to be able to immediately implement the program when licensure is granted.

SFGH will continue to update the JCC-SFGH as the program progresses.

Project Update

Emergency Resource Map

SFGH and the SFGH Foundation are collaborating with the Jewitt Foundation to develop an emergency resource map and tip sheet for San Franciscans to use in time of disasters or other emergency conditions. The creation, design, printing and distribution of the map are made possible by a generous donation of the Jewitt Foundation. Special attention is being paid to the map's design to incorporate ease of use, quick reference tip sheets and clearly marked locations of neighborhood police, fire and hospital locations. The map will also be available in English, Spanish and Chinese, as the most common languages in San Francisco. SFGH Emergency Response Planner, Ann Stangby, and Dr. Marshall Isaacs, SFFD EMS Medical Director, are working with the Foundation as "content experts" for this project. Prior to production, the SFGH Foundation will be requesting content feedback from many City public safety and emergency health care experts to ensure that the most up-to-date information is incorporated into the map. Plans are under way for introducing the Emergency Resource Map at an April 2002 disaster awareness event hosted by the Jewitt and SFGH Foundation.

SFGH is once again grateful to Mr. and Mrs. Fritz Jewitt for their incredible support generosity to the Trauma Center programs.

Ms. O'Connell said that since the February 5th Health Commission meeting, she and her staff have continued to meet with Nuclear Medicine, and realized that the proposal to close Nuclear Medicine would not generate as much savings as originally anticipated. They also realized that Nuclear Medicine needed to operate in a more efficient manner. Staff is developing a proposal with reduced costs and increased revenues, and the remainder of the savings will have to be identified elsewhere.

Ms. O'Connell discussed the impending closure of the UCSF Renal Center. The center is being closed due to on-going financial losses. SFGH Administration has been meeting with UCSF to develop plans for ensuring the provision of outpatient dialysis services to SFGH

patients. They are considering using a for-profit outpatient dialysis provider. Ms. O'Connell described the SFGHMC Plan to Eliminate or Substantially Reduce Medication-related Errors, and offered to have Sharon Kotabe present this plan at a future Joint Conference Committee meeting. Ms. O'Connell acknowledged Chris Wachsmuth and her staff for developing the Emergency Resource Map.

Commissioners' Comments

- Commissioner Umekubo stated that the hospital needs to have Nuclear Medicine in order to be a first class facility. He said that there is a shortage of outpatient dialysis in San Francisco, and the demand is only going to continue to grow. He asked Ms. O'Connell to keep the Health Commission informed about the planning and implementation around the proposed Renal Center closure. With regard to the plan to reduce medication errors, Commissioner Umekubo asked if the hospital would have the computer system in place next year. Dr. Navarro said that they already have the software, and the system should be in place by next year.

4) PATIENT CARE REPORT

The Patient Care Report will be heard at the March Joint Conference Committee, because Sue Currin was out sick.

5) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES

Gregg Sass, CHN Chief Financial Officer, presented the Finance Report (Attachment A). Mr. Sass said that the projected net income has increased to \$8 million, primarily for three reasons: the hospital had been running a much lower patient census, but in January the census increased; revenue deductions now include all new payment structures, which are quite favorable; and energy costs are significantly below the amounts originally budgeted.

Commissioners' Comments

- Commissioner Umekubo asked if the SB 855 allocation will change. Ms. Sass said that he is anticipating an increase in this year's allocation, but nothing is certain until it actually happens.

6) CONSIDERATION AND APPROVAL OF THE MEDICAL STAFF BYLAWS

J. Renee Navarro, M.D., Chief of Staff, presented the amendments to the Medical Staff Bylaws. Dr. Navarro said that the Medical Staff Bylaws Committee met regularly over the past year to review and update the bylaws. Dr. Navarro said that the Bylaws Committee obtained a copy of the evaluation tool used by the California Medical Association and used this to make the needed changes to the bylaws. The JCAHO mock surveyors reviewed the document and did not find any serious problems or oversights. Dr. Navarro said that that recommended changes reflect new areas of focus or verbiage by the CMA and suggestions from the mock surveyors. The most significant policy changes for the medical staff has been the change from Quality and Utilization Management to Performance Improvement and Patient Safety. The bylaws will be considered by the Health Commission at the March 5th meeting.

Commissioners' Comments

- Commissioner Umekubo noticed that changes have been made to proctoring, and asked if this has been a problem in the past. Dr. Navarro replied that the process has been problematic, but has improved. Commissioner Umekubo asked for clarification about when verbal orders must be signed for restraint, and staff responded 24 hours.

Action Taken: The Committee approved the amendments to the Medical Staff Bylaws.

7) PUBLIC COMMENT

None.

8) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

None.

B) Vote on Whether to Hold a Closed Session

Action Taken: The Committee voted to hold a closed session.

The closed session began at 4:25 p.m. People who attended the closed session are the same as those who attended the open session, with the exception of Yuhum Digdigian, Gregg Sass and Wahid Choudhury.

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

APPROVAL OF CLOSED SESSION MINUTES OF JANUARY 15, 2002

Action Taken: The Committee approved the January 15, 2002 closed session minutes.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

CONSIDERATION OF CREDENTIALING MATTERS

Action Taken: The Committee approved the February credentials report.

MEDICAL STAFF REPORT

JCAHO ACTIVITIES UPDATE

D) Reconvene in Open Session

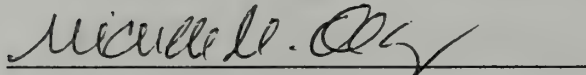
The Committee reconvened in open session at 5:15 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose discussions held in closed session.

9) **ADJOURNMENT**

The meeting was adjourned at 5:15 p.m.



Michele M. Olson

Executive Secretary to the Health Commission

Attachment (1)

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/2002

Month Ending: JAN 31, 2002

(In Thousands of Dollars)

MONTHLY						ANNUAL					
Fav/(Unfav)						Fav/(Unfav)					
Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual	
GROSS PATIENT REVENUE:											
1	17,780	14,914	2,866	19.2%	9,276	Inpatient Medi-Cal Revenue	186,724	171,999	14,725	8.6%	153,288
2	4,227	4,820	(593)	-12.3%	4,500	Outpatient Medi-Cal Revenue	50,139	56,751	(6,612)	-11.7%	50,578
3	6,110	5,230	880	16.8%	6,068	Inpatient Medicare Revenue	66,861	60,321	6,540	10.8%	63,264
4	2,037	1,897	140	7.4%	2,181	Outpatient Medicare Revenue	23,770	22,337	1,433	6.4%	23,428
5	8,915	8,986	(71)	-0.8%	13,596	Inpatient Other Revenue	123,567	103,635	19,932	19.2%	117,606
6	6,155	4,787	1,368	28.6%	5,105	Outpatient Other Revenue	72,349	56,365	15,984	28.4%	63,963
7											
8	45,224	40,634	4,590	11.3%	40,726	TOTAL PATIENT SERVICE REVENUE	523,410	471,408	52,002	11.0%	472,127
9											
REVENUE DEDUCTIONS:											
11	5,137	6,731	1,594	23.7%	11,583	Charity Care	64,328	76,680	12,352	16.1%	80,879
12	15,807	15,104	(703)	-4.7%	13,248	Provision for Medi-Cal Adjustments	185,436	175,229	(10,207)	-5.8%	151,423
13	5,913	2,563	(3,350)	-130.7%	7,389	Provision for Medicare Adjustments	48,211	29,737	(18,474)	-62.1%	41,734
14	5,586	4,056	(1,530)	-37.7%	(2,798)	Provision for Other Adjustments	72,612	48,463	(24,149)	-49.8%	60,550
15	1,875	2,112	237	11.2%	1,917	Provision for Bad Debt	22,500	24,500	2,000	8.2%	19,021
16	34,318	30,566	(3,752)	-12.3%	31,339	TOTAL REVENUE DEDUCTIONS	393,087	354,609	(38,478)	-10.9%	353,607
17											
18	10,906	10,068	838	8.3%	9,387	NET PATIENT SERVICE REVENUE	130,323	116,799	13,524	11.6%	118,520
19											
OTHER OPERATING REVENUE:											
21	710	710	0	n/a	276	Capitation/Managed Care Settlement	8,519	8,519	0	n/a	10,124
22	421	421	0	n/a	388	Short Doyle	5,054	5,054	0	n/a	4,654
23	0	0	0	n/a	0	MHRF Funding	0	0	0	n/a	8,453
24	10,515	10,515	0	n/a	10,626	SB855	126,183	126,183	0	n/a	104,112
25	1,642	1,808	(166)	-9.2%	1,808	SB1255	19,700	21,700	(2,000)	-9.2%	22,000
26	108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300
27	594	660	(66)	-10.0%	830	Revenue from Other City Departments	7,132	7,924	(792)	-10.0%	9,391
28	0	0	0	n/a	0	Prior Year Settlement	362	0	362	n/a	(4,556)
29	333	365	(32)	-8.8%	292	MAA & Other Net Patient Revenue	4,000	4,381	(381)	-8.7%	4,085
30	14,323	14,587	(264)	-1.8%	14,328	TOTAL OTHER OPERATING REVENUE	172,250	175,061	(2,811)	-1.6%	159,563
31											
32	25,229	24,655	574	2.3%	23,715	TOTAL OPERATING REVENUE	302,573	291,860	10,713	3.7%	278,083
33											
OPERATING EXPENSES:											
35	15,107	13,739	(1,368)	-10.0%	13,704	Personnel Services	167,372	162,986	(4,386)	-2.7%	154,242
36	3,622	3,253	(369)	-11.3%	3,131	Mandatory Fringe Benefits	40,131	39,079	(1,052)	-2.7%	37,020
37	8,608	8,358	(250)	-3.0%	8,255	Contractual Services	103,300	100,300	(3,000)	-3.0%	91,788
38	2,100	2,100	0	n/a	2,148	Materials and Supplies (excl. Pharm.)	25,205	25,205	0	n/a	25,582
39	1,167	1,167	0	n/a	1,200	Pharmaceuticals	14,000	14,000	0	n/a	12,621
40	605	630	25	4.0%	383	Facilities Maintenance & Capital Outlay	7,262	7,562	300	4.0%	3,173
41	1,304	1,455	151	10.4%	1,207	Services of Other Departments	15,650	17,461	1,811	10.4%	15,135
42	(99)	(110)	(11)	-10.0%	(106)	Expenditure Recovery	(1,187)	(1,319)	(132)	-10.0%	(639)
43	7,935	8,185	250	3.1%	8,185	Operating Transfer Out	95,225	98,225	3,000	3.1%	68,730
44	427	427	0	n/a	187	Intrafund Transfer	5,129	5,129	0	n/a	2,248
45	0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0
46	551	635	84	13.2%	428	Continuing Projects	6,618	7,618	1,000	13.1%	5,047
47	41,327	39,839	(1,488)	-3.7%	38,722	TOTAL OPERATING EXPENSES	478,705	476,246	(2,459)	-0.5%	414,947
48											
49	(16,098)	(15,184)	(914)	6.0%	(15,007)	OPERATING INCOME/(LOSS)	(176,132)	(184,386)	8,254	-4.5%	(136,864)
50											
NON-OPERATING REVENUE:											
52	8,020	8,020	0	n/a	6,630	General Fund	96,245	96,245	0	n/a	70,682
53	5,093	5,093	0	n/a	5,093	Realignment	61,113	61,113	0	n/a	61,113
54	285	285	0	n/a	317	Prop 99	3,423	3,423	0	n/a	3,102
55	487	487	0	n/a	212	Transfer In and Project-Related	5,846	5,846	0	n/a	3,728
56	1,207	1,207	0	n/a	838	Carryforward	14,482	14,482	0	n/a	(576)
57	73	73	0	n/a	73	Cafeteria	877	877	0	n/a	758
58	200	200	0	n/a	439	Miscellaneous	2,400	2,400	0	n/a	2,610
59	15,365	15,365	0	n/a	13,602	TOTAL NON-OPERATING REVENUE	184,386	184,386	0	n/a	141,417
60											
61	(733)	181	(914)	74.6%	(1,405)	NET INCOME/(LOSS)	8,254	0	8,254	n/a	4,553

San Francisco General Hospital
SUMMARY STATISTICAL INFORMATION - FYE 6/30/01
Month Ending: JAN 31, 2002

CURRENT MONTH						YEAR-TO-DATE					
Actual	Budget	Variance	% Var	Prior Year	KEY VOLUME INDICATORS	Actual	Budget	Variance	% Var	Prior Year	
1,481	1,479	2	0.1%	1,464	Discharges (incl. MHRF)	10,041	10,052	(11)	-0.1%	10,511	
2,042	2,063	(21)	-1.0%	2,060	Discharges (incl. MHRF)	13,944	14,102	(158)	-1.1%	14,781	
					Adjusted Discharges (incl. MHRF)						
199	186	13	6.8%	196	Average Daily Census	193	178	15	8.1%	191	
90	92	(2)	-2.6%	91	Acute Med/Surg ADC	92	92	0	0.1%	91	
28	21	7	33.8%	25	Psych ADC	26	20	6	31.5%	21	
316	299	17	5.8%	312	Skilled Nursing ADC	311	290	21	7.2%	301	
138	140	(2)	-1.5%	138	Total ADC excl. MHRF	139	140	(1)	-0.7%	131	
454	439	15	3.5%	450	MHRF ADC	450	430	20	4.6%	441	
7	7	(0.2)	-2.9%	5	Total Adult ADC	7	7	0.0	n/a	6	
6.7	6.4	(0.3)	-4.7%	6.7	Nursery ADC	6.8	5.9	(0.9)	-15.3%	6.1	
1.286	1.295	0.009	0.7%	1.227	Average Length of Stay (excl. MHRF)	1.286	1.295	0.009	0.7%	1.221	
					Medicare Case Mix Index						
48.7%	48.6%	0.1%	0.1%	33.8%	Payer Mix (Gross Revenue)	45.3%	48.5%	-3.3%	-6.7%	45.2	
18.0%	17.5%	0.5%	2.9%	20.3%	Medi-Cal	17.3%	17.5%	-0.2%	-1.0%	18.0	
33.3%	33.9%	-0.6%	-1.7%	45.9%	Medicare	37.4%	34.0%	3.4%	10.1%	36.8	
100.0%	100.0%	0.0%	n/a	100.0%	Other	100.0%	100.0%	0.0%	n/a	100.0	
					Total						
5,807	4,858	949	19.5%	3,547	Patient Days	37,945	32,698	5,247	16.0%	35,101	
2,330	2,094	236	11.3%	2,682	Medi-Cal Patient Days (excl. MHRF)	15,000	14,095	905	6.4%	14,771	
1,668	2,317	(649)	-28.0%	3,447	Medicare Patient Days (excl. MHRF)	13,954	15,598	(1,644)	-10.5%	15,961	
9,805	9,269	536	5.8%	9,676	Other Patient Days (excl. MHRF)	66,899	62,391	4,508	7.2%	65,831	
					Total Patient Days(excl. MHRF)						
6,229	5,410	819	15.1%	4,193	Medi-Cal Patient Days	40,546	36,768	3,778	10.3%	39,701	
2,330	2,121	209	9.9%	2,460	Medicare Patient Days	15,000	14,415	585	4.1%	14,771	
5,521	6,078	(557)	-9.2%	7,313	Other Patient Days	41,246	41,305	(59)	-0.1%	40,561	
14,080	13,609	471	3.5%	13,966	Total Patient Days	96,792	92,488	4,304	4.7%	95,031	
19,410	18,984	426	2.2%	19,654	Adjusted Patient Days	134,396	129,762	4,634	3.6%	133,701	
84.6%	81.8%	2.8%	3.4%	84.0%	% Occupancy (available beds)	83.8%	80.1%	3.7%	4.6%	82.3	
					KEY OPERATIONAL INDICATORS						
2,416.7	2,380.0	(36.7)	-1.5%	2,207.0	Labor	2,359.4	2,380.0	20.6	0.9%	2,245.1	
287.2	329.0	41.8	12.7%	424.0	FTEs - Productive	335.9	329.0	(6.9)	-2.1%	362.1	
2,703.9	2,709.0	5.1	0.2%	2,631.0	FTEs - Non-Productive	2,695.3	2,709.0	13.7	0.5%	2,608.1	
334.0	334.0	0.0	n/a	334.0	Total FTEs - SFGH Only	334.0	334.0	0.0	n/a	334.1	
3,037.9	3,043.0	5.1	0.2%	2,965.0	UC Non-Academic FTEs	3,029.3	3,043.0	13.7	0.5%	2,942.1	
4.9	5.0	0.1	2.0%	4.7	Grand Total FTEs Incl. UC	4.8	5.0	0.2	3.1%	4.1	
\$ 64,412	\$ 60,126	(\$4,286)	-7.1%	\$60,094	FTEs Per AOB (incl. UC)	\$ 62,343	\$60,126	(\$2,217)	-3.7%	\$ 58,751	
24.0%	24.0%	0.0%	n/a	22.8%	Average Labor Cost per SFGH FTE	24.0%	24.0%	0.0%	n/a	23.5	
					Fringe Benefits as % of Salary						
\$ 1,300	\$ 1,297	\$3	0.2%	\$1,243	Revenues	\$ 1,302	\$1,316	(\$14)	-1.1%	\$1,301	
\$ 668	\$ 642	\$26	4.0%	\$604	Oper. Rev. Per Adjusted Patient Day (incl. MHRF)	\$ 663	\$645	\$18	2.8%	\$641	
\$ 12,355	\$ 11,936	\$419	3.5%	\$11,855	Oper. Rev. (excl. SB855/1255/GME)/APD	\$ 12,544	\$12,106	\$438	3.6%	\$11,791	
\$ 6,349	\$ 5,910	\$439	7.4%	\$5,766	Oper. Rev. Per Adjusted Discharge	\$ 6,387	\$5,935	\$452	7.6%	\$5,851	
					Oper. Rev. (excl. SB855/1255/GME)/Adj. Discharge						
\$ 2,129	\$ 2,065	(\$64)	-3.1%	\$1,970	Expenses	\$ 2,080	\$2,079	(\$1)	0.0%	\$1,971	
\$ 1,720	\$ 1,634	(\$86)	-5.3%	\$1,554	Operating Exp. Per Adjusted Pt. Day	\$ 1,667	\$1,637	(\$30)	-1.8%	\$1,541	
\$ 20,239	\$ 19,005	(\$1,234)	-6.5%	\$18,797	Operating Exp.(excl. IGT)/Adj. Pt. Day	\$ 20,050	\$19,131	(\$919)	-4.8%	\$17,841	
\$ 16,353	\$ 15,037	(\$1,316)	-8.8%	\$14,823	Operating Exp. Per Adj. Discharge	\$ 16,066	\$15,068	(\$998)	-6.6%	\$13,961	
30.0%	32.3%	2.3%	7.1%	35.7%	Operating Exp.(excl. IGT)/Adj. Discharge	30.8%	32.8%	2.0%	6.1%	34.1	
					Supply Expense as % of Net Pt. Revenue						
91	80	(11)	-13.8%	113	Days Revenue in Accounts Receivable	91	80	(11)	-13.8%	111	

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Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

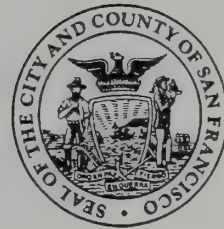
David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, March 12, 2002
3:45 p.m. - 5:30 p.m.

1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF FEBRUARY 12, 2002
**Minutes of February 12, 2002*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGHMC)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Officer)
**Report*

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5) FOR DISCUSSION: FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
**Report*

6) FOR DISCUSSION: 4th QUARTER ENVIRONMENT OF CARE (EOC) REPORT
(John Kanaley, Sr. Associate Administrator for Support Services)
**Report*

7) FOR DISCUSSION: PERFORMANCE IMPROVEMENT AND PATIENT SAFETY EDUCATION
(Hiroshi Tokubo, CHN Director for Quality Management
John Luce, MD; Medical Director SFGHMC Quality Management)
**Education*

8) PUBLIC COMMENT**

9) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

B) Vote on Whether to Hold a Closed Session

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: APPROVAL OF CLOSED SESSION MINUTES OF FEBRUARY 12, 2002

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: CONSIDERATION OF CREDENTIALING MATTERS
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION: MEDICAL STAFF REPORT
J. Renee Navarro, M.D., Chief of Staff

D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)(2) and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

10) ADJOURNMENT

- * Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.
- * Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at:
www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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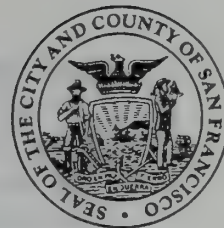
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MINUTES

JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, March 12, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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1) CALL TO ORDER

The San Francisco General Hospital Joint Conference Committee meeting was called to order by Commissioner Lee Ann Monfredini at 3:45 p.m.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.
Commissioner Edward A. Chow, M.D.

Staff: Wahid Choudhury, Sue Currin, Myra Garcia, Mozettia Henley,
John Kanaley, Beth Maloney, Alison Moed, J. Renee Navarro,
M.D., Gene O'Connell, Roland Pickens, Gregg Sass, Hiro Tokubo,
Chris Wachsmuth, Connie Young, Monique Zmuda

2) APPROVAL OF MINUTES OF FEBRUARY 12, 2002

Action Taken: The minutes of the February 12, 2002 SFGH JCC meeting were approved with one correction. The Patient Care Report should read: "Ms. O'Connell provided a brief summary of the Patient Care Report on behalf of Sue Currin. Yuhum Digidigan, Director of Nursing Operations, was present to answer any questions."

3) HOSPITAL HEALTHCARE UPDATE

Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center, presented the Hospital Healthcare Update.

PBM Contract Renewal

The contract with Pharmaceutical Care Network, our Pharmacy Benefits Management (PBM) contractor, was modified in December 2001 to a 15-month term ending March 31, 2002. At the next Health Commission meeting on March 19, a request to renew the contract for an additional 12-month period will be forwarded. The request will be for a total contract amount of \$9.24 million, for the period April 1, 2002 through March 31, 2003. As noted in the January 2002 PBM status report presented to Commissioners, pharmaceutical and PBM costs continue to increase. The following trends are driving rising PBM costs:

- Increased utilization of PBM network pharmacies (67% of prescriptions currently being filled by non-SFGH pharmacies.)
- Increased utilization of the prescription benefit by eligible CHN patients (less than 15% of eligible patients accessed prescription benefit services in December 2000; more than 27% of eligible patients accessed services in January 2002.)
- Increased overall prescription volume of approximately 6% (due to more patients utilizing services offered by this contract)
- Increased average cost per prescription from approximately \$48.00 in December 2000 to approximately \$51.00 in January 2002.
- Increased cost of pharmaceuticals of up to 15%, nationwide.

To mitigate this trend toward increasing utilization and increased costs, the following changes to the contract were negotiated. Some of the changes that were policy as opposed to contractual revisions have already been effected.

- Reduced per prescription reimbursement to network pharmacies
- Reduced per claim administrative processing fee
- Reduced percentage retention by PBM of manufacturer rebates
- Reduced days supply per prescription dispensed by PBM pharmacies (except to treat certain medication used for chronic, long-term conditions)

Legislative and lobbying activities described in the January 2002 report to the Health Commission continue to be actively pursued to further help contain costs. These activities are:

- Demonstration project with the Office of Pharmacy Affairs
- Optimize opportunities made available through passage of SB 340

The contract for the Mental Health PBM is due to end June 30, 2002, and renewal will be proposed to end March 31, 2003. The Department will evaluate the scope and costs of both of these contracts in the interim, and propose a restructured contract to encompass DPH-wide prescription services for the period beginning April 1, 2003.

JCAHO Dates

SFGH have been informed by JCAHO on March 1st that the Hospital Survey dates will be from April 22nd to April 26th, one month earlier than anticipated. The survey dates for the MHRF (Long-Term Care) and Bridge to Wellness (Partial-Hospitalization) have not yet been set. The survey

dates, according to SFGH's coordinator at JCAHO, could be set within anywhere between 0-12 days from the Hospital survey dates. This week, SFGH will be following up with the JCAHO coordinator on these dates.

Cathy Chou, who had been coordinating JCAHO preparation activities at SFGHMC, has been placed on bed rest for the remainder of her pregnancy. To ensure that preparation activities are on track, especially with an earlier date, Connie Young has been assigned to assist in coordinating preparation and readiness activities with Hiroshi Tokubo and the Quality Management staff. In addition, SFGH will be utilizing the remainder of the JCAHO consultant's contract to assist in areas such as document binder review and functional interviews.

Although JCAHO is only five weeks away, it is felt that SFGH staff are on track and will be ready to show and tell all of the surveyors the wonderful things done here at SFGHMC. One example of their readiness is the Performance Improvement Boards that were showcased throughout the hospital over the last two weeks. A team including Gene O'Connell, Renee Navarro, Hiroshi Tokubo, and Ken Jones rounded all of the units and departments rating each performance improvement board on a pre-determined set of criteria including content, creativity, relevance, clarity and visibility. The winners, which were announced at this morning's Management Forum, included:

- 6A Pediatric Pain Management with emphasis on sickle cell and trauma
- Sterile Processing and Distribution (SPD) Cost Saving and Waste Reduction
- 3M Fine Needle Aspiration
- Dietary Cook-Chill Advance Meal Delivery System

Honorable Mentions to:

- 5M and 6C Breast Feeding Support
- Environment of Care (EOC) Improving Employee knowledge of EOC, Health and Safety, Injury/Illness Prevention

SFGH will continue to update the JCC-SFGH as the JCAHO survey dates steadily approach.

AB 508 California Hospital Security Act DHS Evaluation

SFGH has been selected by the California State Department of Health Services (DHS) to be surveyed on how the security plan has been implemented in response to AB 508, California Hospital Security Act. AB 508 was passed by the California legislature in 1995 and required hospitals to conduct a security assessment and develop a security plan for employees. DHS, in collaboration with the University of Iowa and the University of California, Los Angeles (UCLA), is now conducting a survey of hospital's security plans with the interest of developing recommendations for employers and employees throughout the health care industry. As part of their survey, they will be asking for documents such as OSHA logs, incident reports, training materials, and written security plans, as well as interviewing certain personnel. All information will be kept confidential by DHS.

John Kanaley, Senior Associate Administrator for Support Services, and Alison Moed, Director of Risk Management, are coordinating DHS' visit and are confident that security plans are in compliance with AB 508 and actually exceed expectations of AB 508. SFGH will continue to update JCC-SFGH as this evaluation progresses.

Project Update

IMPACT - Improving, Access, Counseling, and Treatment

San Francisco General Hospital Medical Center is applying to be a new treatment site for the State's Prostate Cancer Treatment Program IMPACT. IMPACT, also known as Improving, Access, Counseling and Treatment is sponsored by the State California Department of Health Services and serves uninsured men in California who do not qualify for Medi-Cal or Medicare, with annual incomes less than 200% of the federal poverty level (or \$17,180 for an individual) and who have been diagnosed with Prostate Cancer. The program is administered by UCLA who was awarded the contract by DHS last year and is funded for three years with a \$50 million budget.

During the program's first year, UCLA Medical Center, UCSF Medical Center, and UC Davis Medical Center served as regional IMPACT sites. The program is now expanding to additional sites, including SFGHMC and Alameda's Highland Hospital. As an IMPACT treatment site, SFGHMC will receive referrals from UCLA and provide certain prostate cancer treatment services, including 18 months follow-up care. The IMPACT program does not include screenings for prostate cancer, although UCLA is working on obtaining funding through endowments. UCLA will also be responsible for determining a patient's eligibility for the Program in accordance with eligibility policies and procedures established by UCLA and the State.

As a treatment site, SFGH will be reimbursed for providing the services at Medicare DRG rates. Within the last six months, SFGH has provided prostate cancer services to approximately 5 - 10 uninsured men who have been diagnosed with prostate cancer. Through UCLA-funded increased marketing and development of outreach programs, SFGH hopes to serve more prostate cancer patients in need of services.

The contract is tentatively dated to be presented to the Health Commission on April 2, 2002 for review and approval. Upon approval, it will subsequently be presented to the Board of Supervisors for their approval.

4) PATIENT CARE REPORT

Sue Currin, RN, Chief Nursing Officer, presented the Patient Care Report (Attachment A).

5) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES

Gregg Sass, CHN Chief Financial Officer, presented the Finance Report (Attachment B).

Commissioners' Comments

- Commissioner Umekubo commended the Department for controlling the cost of pharmaceuticals.

6) 4th QUARTER ENVIRONMENT OF CARE (EOC) REPORT

John Kanaley, Sr., Associate Administrator for Support Services, presented the 4th Quarter Environment of Care (EOC) Report. Mr. Kanaley updated the committee members on the status of various activities undertaken by the EOC Safety Committee.

7) **PERFORMANCE IMPROVEMENT AND PATIENT SAFETY EDUCATION**

Hiroshi Tokubo, CHN Director for Quality Management, presented the Performance Improvement and Patient Education report. Mr. Tokubo gave a Power Point presentation (Attachment C) that overviewed the various elements of the Performance Improvement and Patient Safety (PIPS) Program at San Francisco General Hospital. The overview included JCAHO standards, the PIPS program and PIPS committee, the role of committees and staff, the SFGH performance improvement methodologies, the ORXY initiative and the patient safety plan.

8) **PUBLIC COMMENT**

None.

9) **CLOSED SESSION**

A) **Public Comments on All Matters Pertaining to the Closed Session**

None.

B) **Vote on Whether to Hold a Closed Session**

Action Taken: The Committee voted to hold a closed session.

The closed session began at 4:55 p.m.

C) **Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1**

APPROVAL OF CLOSED SESSION MINUTES OF FEBRUARY 12, 2002

Action Taken: The Committee approved the closed session minutes for February 12, 2002.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

CONSIDERATION OF CREDENTIALING MATTERS

Action Taken: The Committee approved the Credentials report.

MEDICAL STAFF REPORT

Action Taken: The Committee approved the recommendation of the Medical Executive Committee that Dr. Douglas Hanks continue as Acting Chief of the Anatomic Pathology Service, pending appointment of the new chief. The Committee also approved the appointment of Dr. Walter Finkliner as the new Chief of Anatomic Pathology.

D) Reconvene in Open Session

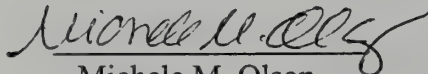
The Committee reconvened in open session at 5:25 a.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in closed session.

10) ADJOURNMENT

The meeting was adjourned at 5:25 p.m.



Michele M. Olson
Executive Secretary to
the Health Commission

Attachment (3)

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 3/12/02

Sue Currin, RN, MS, Chief Nursing Officer

1. Nursing Leadership Council Report to the SFGHMC Joint Conference Committee

A meeting was held with Mitch Katz, Gene O'Connell, Barbara Garcia, Larry Funk and Tony Wagner on March 1, 2002 to discuss the Nursing Leadership Council's mission, purpose, goals, accomplishments and future direction. The NLC will provide periodic reports to each of the JCC's and meet biannually with members of the DPH Executive Staff. The following is a summary from the NLC:

A. Mission

The NLC mission is to:

- Promote the mission and vision of the Department by providing leadership, communication, education, and promotion of nursing throughout the Department of Public Health (DPH).
- To facilitate the integration of nursing care across the population served.

B. Purpose

The purpose of the NLC is to:

- Represent the diversity of nursing practice throughout DPH.
- Speak as the voice of Nursing within DPH.
- Make recommendations related to nursing practice and nursing operations.
- Promote excellence in nursing practice.
- Assure communication throughout DPH on issues related to nursing.
- Monitor legislation and policy development.
- Develop and influence policy and legislation for the benefit of nursing and the population it serves.
- Promote a safe work environment.

C. Goals

Consistent with the Strategic Plan for the Department, the NLC has identified the following goals:

- Improve recruitment, retention, and training of nursing staff.
- Promote communication between nurses throughout DPH.

D. Summary of Activities 1997-2001

- Developed NLC Bylaws and method of governance.
- Achieved full representation from RNs throughout DPH on NLC.
- Hosted presentation by Fran Tate, member of the California Board of Registered Nursing.
- Hosted presentation by Colleen Johnson, Interim Director, Policy and Planning, addressing current legislative activities.

- Completed a workforce survey in 2000 regarding recruitment retention issues for RNs in DPH.
- Attended Board of Registered Nursing meeting.

C. Proposed 2002 Activities

- Develop Philosophy of Nursing for the Department of Public Health.
- Develop Nursing Website.
- Develop and distribute quarterly newsletter for DPH Nurses beginning March 2002.
- Host National Nurse Week Celebrations in May 2002, including, but not limited to:
 - Leadership Invitational for local and DPH Nurse
 - Leaders with presentation by Mary E. Foley, current American Nurses Association (ANA) President.
 - Nursing Film Festival featuring films produced by and highlight the nursing profession.
- Monitor legislation (Local, State, and Federal).
- Invite Deans/Chairs of local Schools of Nursing to NLC meetings to strengthen relationships between academia and service arenas.

2. Recruitment/Retention Activities

Retention: The Nursing Retention and Recruitment Committee has been meeting on a monthly basis and is prepared to administer a nursing satisfaction survey in the next month. Survey results will be used to guide future committee projects. Additionally, the committee has begun planning for Nurse's Week activities, which will occur during the week of May 6. A recruitment/recognition reception is planned for May 7 featuring Ruth Ann Terry, Executive Director of the California Board of Registered Nursing. Student nurses from local nursing schools will be invited to attend the reception and will be greeted by SFGH "nursing ambassadors" who will welcome the students and talk with them about the opportunities at SFGH. The program will also acknowledge SFGH nurses for the "difference they make" through their work.

Recruitment:

Leslie Holpit participated in Career Day at John O'Connell High School in the Mission on February 25. Leslie participated in a panel presentation to students interested in health care careers. Focusing on the benefits and realities of a nursing career, Leslie spoke with approximately 60 students during the half-day program.

Leslie is also participating in a work group with representatives from City College, SEIU Local 250, Kaiser, and the San Francisco Private Industry Council to pursue training grants to fund the educational expenses for DPH employees enrolled in nursing school.

On March 4, Leslie attended a job fair at the College of San Mateo School of Nursing. Future job fairs include those at San Francisco State and City College.

Two Medical-Surgical training programs are planned. The first will be in April with the second in July in order to attract new graduate RNs to join SFGH. We also scheduled an ED and Critical Care Training Program in July.

The current overall RN vacancy rate for inpatient and outpatient areas is 12% (~75 FTE), LVN/LPT is also 12% (25 FTE). We have processed our first Med-Surg RN through the Employment-Based Immigrant Petition approved by the Immigration and Naturalization Service. The RN will begin work in 4-6 weeks. Two additional petitions are still being processed.

3. Diversion Summary Report

See attached.

PTCARE 3-7-02

San Francisco General Hospital

Diversion Report

February 2002

Executive Summary

The Emergency Department [ED] recorded 34 episodes of diversion for 304 hours representing a rate of 45.2% in **February 2002**. This is a 5.5% increase in diversion since January 2002.

The 32 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from Previous Month
Total diversion	34	304	45.2	5.5%
Trauma override	13	66.75	9.9	6.7%

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, 297 patients were awaiting admission to in-patient beds [ICU-32, 4B/StepDown-88, MedSurg-174, Ward 86-3]. **In February of 2001, the ED was on diversion 37% of the month. Trauma Override was invoked 6% of the month in February of 2001.**

Total diversion was recorded for 34 episodes, a total of 304 hours or a 45.2% rate for February 2002. While on Total Diversion the ED held 297 patients.

Trauma override was recorded for 13 episodes, a total of 66.75 hours or a 9.9% rate for February 2002. This is a 6.7% increase in trauma override from January 2002. While on Trauma override the ED held 82 patients awaiting inpatient beds.

mainly due to overcrowding in the ED

Definitions:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSS definitions:

Total diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Sharon Kennedy R.N.
Base Hospital Coordinator

San Francisco General Hospital
Emergency Department
February 2002
Total Diversion Summary

In February 2002, the Emergency Department recorded 34 episodes of Total Diversion for 304 hours and 28 min, a percentage of 42.3% for the month.

Date	Length	Summary of Event
02/02/02	0435-0650 (2h 15m)	34 patients in the ED Admits: 1-ICU; 2-4B; 3-Floor Fast Track: Closed ED waiting room: 6 urgent patients
02/02/02	1420-1838 (4h 18m)	29 patients in the ED Admits: 1-4B; 4-Floor Fast Track: Open ED waiting room: 3 urgent patients
02/03/02	0105-0700 (6h 5m)	39 patients in the ED Admits: 2-4B; 1-Floor Fast Track: Closed ED waiting room: 10 urgent patients
02/03/02	1930-2200 (2h 30m)	29 patients in the ED Admits: 2-ICU; 2-4B; 6-Floor Fast Track: Closed ED waiting room: 6 urgent patients
02/04/02	1520-1845 (3h 25m)	34 patients in the ED Admits: 6-Floor Fast Track: Closed ED waiting room: 4 urgent patients
02/05/02	1119-0235 (15h 16m)	38 patients in the ED Admits: 2-ICU; 5-4B; 18-Floor Fast Track: Closed ED waiting room: 0 urgent patients
02/06/02	1205-2145 (9h 40m)	40 patients in the ED Admits: 8-ICU; 2-4B; 3-Ward 86; 2-Floor Fast Track: Open ED waiting room: 10 urgent patients
02/07/02	1345-0200 (8h 15m)	32 patients in the ED Admits: 2-4B; 7-Floor Fast Track: Open ED waiting room: 12 urgent patients
02/08/02	0932-1910 (9h 38m)	34 patients in the ED Admits: 2-4B; 8-Floor Fast Track: Open ED waiting room: 6 urgent patients
02/08/02	2125-0045 (3h 20m)	43 patients in the ED Admits: 3-4B; 7-Floor Fast Track: Open ED waiting room: 10 urgent patients
02/09/02	1807-0130 (7h 23m)	33 patients in the ED Admits: 1-ICU; 3-4B; 3-Floor Fast Track: Closed ED waiting room: 0 urgent patients

02/10/02	1634-1925 (2h 51m)	36 patients in the ED Admits: 2-4B; 4-Floor Fast Track: Closed ED waiting room: 0 urgent patients
02/11/02	0105-0505 (4h)	37 patients in the ED Admits: 2-ICU; 2-4B; 2-Floor Fast Track: Closed ED waiting room: 10 urgent patients
02/11/02	1300-0650 (17h 50m)	37 patients in the ED Admits: 1-4B; 6-Floor Fast Track: Open ED waiting room: 18 urgent patients
02/12/02	1155-0100 (13h 5m)	40 patients in the ED Admits: 4-4B; 6-Floor Fast Track: Open ED waiting room: 7 urgent patients
02/13/02	1335-1830 (4h 55m)	48 patients in the ED Admits: 2-4B; 3-Floor Fast Track: Open ED waiting room: 5 urgent patients
02/13/02	1940-2250 (3h 10m)	32 patients in the ED Admits: 4-4B; 3-Floor Fast Track: Open ED waiting room: 6 urgent patients
02/14/02	1600-0210 (10h 10m)	36 patients in the ED Admits: 4-4B; 12-Floor Fast Track: Open ED waiting room: 14 urgent patients
02/15/02	1905-0625 (11h 20m)	50 patients in the ED Admits: 3-4B; 2-Floor Fast Track: Open ED waiting room: 16 urgent patients
02/16/02	1250-1440 (1h 50m)	33 patients in the ED Admits: 3-Floor Fast Track: Open ED waiting room: 3 urgent patients
02/17/02	1235-1840 (6h 5m)	32 patients in the ED Admits: 3-4B; 3-Floor Fast Track: Open ED waiting room: 5 urgent patients
02/18/02	1505-1915 (4h 10m)	33 patients in the ED Admits: 1-Floor Fast Track: Open ED waiting room: 8 urgent patients
02/18/02	2330-0400 (4h 30m)	32 patients in the ED Admits: 1-4B; 5-Floor Fast Track: Closed ED waiting room: 7 urgent patients
02/19/02	1600-0636 (14h 34m)	42 patients in the ED Admits: 5-4B; 5-Floor Fast Track: Open ED waiting room: 16 urgent patients
02/20/02	1330-0405 (14h 35m)	38 patients in the ED Admits: 1-ICU; 3-4B; 6-Floor Fast Track: Open ED waiting room: 10 urgent patients

02/21/02	1840-0130 (6h 50m)	32 patients in the ED Admits: 3-4B; 8-Floor Fast Track: Closed ED waiting room: 16 urgent patients
02/23/02	1750-1955 (2h 5m)	31 patients in the ED Admits: 3-4B Fast Track: Closed ED waiting room: 8 urgent patients
02/24/02	0015-0300 (2h 45 m)	28 patients in the ED Admits: 1-ICU; 4-4B; 3-Floor Fast Track: Closed ED waiting room: 12 urgent patients
02/24/02	1456-2050 (5h 54m)	37 patients in the ED Admits: 4-4B; 2-Floor Fast Track: Closed ED waiting room: 14 urgent patients
02/25/02	1400-1900 (5h)	42 patients in the ED Admits: 2-ICU; 3-4B Fast Track: Open ED waiting room: 10 urgent patients
02/26/02	1300-0630 (17h 30m)	38 patients in the ED Admits: 2-4B; 10-Floor Fast Track: Open ED waiting room: 11 urgent patients
02/27/02	1345-0619 (16h 34m)	41 patients in the ED Admits: 1-ICU; 2-4B; 9-Floor Fast Track: Open ED waiting room: 24 urgent patients
02/28/02	1345-1900 (5h 15m)	34 patients in the ED Admits: 1-ICU; 2-4B; 6-Floor Fast Track: Open ED waiting room: 5 urgent patients
02/28/02	2310-0430 (5h 20m)	46 patients in the ED Admits: 2-4B; 10-Floor Fast Track: Closed ED waiting room: 12 urgent patients

San Francisco General Hospital
Emergency Department
February 2002
Trauma Override Summary

The Emergency Department recorded 13 episodes of Trauma Override for 66 hours and 49 min, a percentage of 9.9% for the month of February 2002.

Date	Length	Summary of Event
02/02/02	1535-1838 (3h 3m)	911-1 912-1 910-1
02/06/02	1500-2145 (6h 45m)	911-0 912-1 910-0
02/07/02	1525-2215 (6h 15m)	911-2 912-3 910-0
02/08/02	1520-1800 (2h 40m)	911-1 912-0 910-0
02/09/02	1807-0130 (4h 23m)	911-1 912-0 910-0
02/11/02	1754-2428 (6h 34m)	911-1 912-1 910-0
02/12/02	1953-0100 (5h 7m)	911-1 912-1 910-0
02/19/02	1945-0300 (7h 15m)	911-1 912-0 910-0
02/20/02	2030-0405 (7h 35m)	911-1 912-4 910-0
02/25/02	1900-0204 (6h 24m)	911-1 912-2 910-1
02/26/02	1650-1910 (2h 20m)	911-1 912-1 910-0
02/26/02	2320-0510 (5h 50m)	911-1 912-2 910-0
02/27/02	2355-0159 (2h 4m)	911-1 912-0 910-0

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/2002

Month Ending: FEB 28, 2002

(In Thousands of Dollars)

MONTHLY						ANNUAL					
Fav/(Unfav)						Fav/(Unfav)					
Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual	
GROSS PATIENT REVENUE:						GROSS PATIENT REVENUE:					
16,042	13,414	2,628	19.6%	10,332	Inpatient Medi-Cal Revenue	187,446	171,999	15,447	9.0%	153,288	
3,962	4,353	(391)	-9.0%	4,242	Outpatient Medi-Cal Revenue	49,814	56,751	(6,937)	-12.2%	50,578	
5,745	4,705	1,040	22.1%	5,927	Inpatient Medicare Revenue	67,121	60,321	6,800	11.3%	63,264	
1,845	1,714	131	7.6%	1,887	Outpatient Medicare Revenue	23,566	22,337	1,229	5.5%	23,428	
7,207	8,083	(876)	-10.8%	9,988	Inpatient Other Revenue	118,932	103,635	15,297	14.8%	117,606	
5,762	4,324	1,438	33.3%	4,981	Outpatient Other Revenue	71,948	56,365	15,583	27.6%	63,963	
<u>40,563</u>	<u>36,593</u>	<u>3,970</u>	<u>10.8%</u>	<u>37,357</u>	TOTAL PATIENT SERVICE REVENUE	<u>518,827</u>	<u>471,408</u>	<u>47,419</u>	<u>10.1%</u>	<u>472,127</u>	
REVENUE DEDUCTIONS:						REVENUE DEDUCTIONS:					
4,571	6,061	1,490	24.6%	3,821	Charity Care	63,144	76,680	13,536	17.7%	80,879	
16,236	13,602	(2,634)	-19.4%	14,003	Provision for Medi-Cal Adjustments	183,399	175,229	(8,170)	-4.7%	151,423	
3,810	2,308	(1,502)	-65.1%	5,202	Provision for Medicare Adjustments	47,899	29,737	(18,162)	-61.1%	41,734	
4,821	3,653	(1,168)	-32.0%	4,242	Provision for Other Adjustments	70,766	48,463	(22,303)	-46.0%	60,550	
1,875	1,902	27	1.4%	1,917	Provision for Bad Debt	22,500	24,500	2,000	8.2%	19,021	
<u>31,313</u>	<u>27,526</u>	<u>(3,787)</u>	<u>-13.8%</u>	<u>29,185</u>	TOTAL REVENUE DEDUCTIONS	<u>387,708</u>	<u>354,609</u>	<u>(33,099)</u>	<u>-9.3%</u>	<u>353,607</u>	
<u>9,250</u>	<u>9,067</u>	<u>183</u>	<u>2.0%</u>	<u>8,172</u>	NET PATIENT SERVICE REVENUE	<u>131,119</u>	<u>116,799</u>	<u>14,320</u>	<u>12.3%</u>	<u>118,520</u>	
OTHER OPERATING REVENUE:						OTHER OPERATING REVENUE:					
710	710	0	n/a	663	Capitation/Managed Care Settlement	8,519	8,519	0	n/a	10,124	
421	421	0	n/a	388	Short Doyle	5,054	5,054	0	n/a	4,654	
0	0	0	n/a	0	MHRF Funding	0	0	0	n/a	8,453	
10,515	10,515	0	n/a	10,626	SB855	126,183	126,183	0	n/a	104,112	
1,642	1,808	(166)	-9.2%	2,008	SB1255	19,700	21,700	(2,000)	-9.2%	22,000	
108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300	
594	660	(66)	-10.0%	830	Revenue from Other City Departments	7,132	7,924	(792)	-10.0%	9,391	
0	0	0	n/a	0	Prior Year Settlement	362	0	362	n/a	(4,556)	
333	365	(32)	-8.8%	292	MAA & Other Net Patient Revenue	4,000	4,381	(381)	-8.7%	4,085	
<u>14,323</u>	<u>14,587</u>	<u>(264)</u>	<u>-1.8%</u>	<u>14,915</u>	TOTAL OTHER OPERATING REVENUE	<u>172,250</u>	<u>175,061</u>	<u>(2,811)</u>	<u>-1.6%</u>	<u>159,563</u>	
<u>23,573</u>	<u>23,654</u>	<u>(81)</u>	<u>-0.3%</u>	<u>23,087</u>	TOTAL OPERATING REVENUE	<u>303,369</u>	<u>291,860</u>	<u>11,509</u>	<u>3.9%</u>	<u>278,083</u>	
OPERATING EXPENSES:						OPERATING EXPENSES:					
13,209	13,582	373	2.7%	11,824	Personnel Services	168,284	162,986	(5,298)	-3.3%	154,242	
3,167	3,257	90	2.8%	3,151	Mandatory Fringe Benefits	40,349	39,079	(1,270)	-3.2%	37,020	
8,608	8,358	(250)	-3.0%	8,362	Contractual Services	103,300	100,300	(3,000)	-3.0%	91,788	
2,100	2,100	0	n/a	2,148	Materials and Supplies (excl. Pharm.)	25,205	25,205	0	n/a	25,582	
1,167	1,167	0	n/a	1,200	Pharmaceuticals	14,000	14,000	0	n/a	12,621	
605	630	25	4.0%	1,406	Facilities Maintenance & Capital Outlay	7,262	7,562	300	4.0%	3,173	
1,304	1,455	151	10.4%	1,207	Services of Other Departments	15,650	17,461	1,811	10.4%	15,135	
(99)	(110)	(11)	-10.0%	(106)	Expenditure Recovery	(1,187)	(1,319)	(132)	-10.0%	(639)	
7,935	8,185	250	3.1%	8,185	Operating Transfer Out	95,225	98,225	3,000	3.1%	68,730	
427	427	0	n/a	187	Intrafund Transfer	5,129	5,129	0	n/a	2,248	
0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0	
551	635	84	13.2%	428	Continuing Projects	6,618	7,618	1,000	13.1%	5,047	
<u>38,974</u>	<u>39,686</u>	<u>712</u>	<u>1.8%</u>	<u>37,992</u>	TOTAL OPERATING EXPENSES	<u>479,835</u>	<u>476,246</u>	<u>(3,589)</u>	<u>-0.8%</u>	<u>414,947</u>	
<u>(15,401)</u>	<u>(16,032)</u>	<u>631</u>	<u>3.9%</u>	<u>(14,905)</u>	OPERATING INCOME/(LOSS)	<u>(176,466)</u>	<u>(184,386)</u>	<u>7,920</u>	<u>4.3%</u>	<u>(136,864)</u>	
NON-OPERATING REVENUE:						NON-OPERATING REVENUE:					
8,020	8,020	0	n/a	7,651	General Fund	96,245	96,245	0	n/a	70,682	
5,093	5,093	0	n/a	5,093	Realignment	61,113	61,113	0	n/a	61,113	
285	285	0	n/a	317	Prop 99	3,423	3,423	0	n/a	3,102	
487	487	0	n/a	212	Transfer In and Project-Related	5,846	5,846	0	n/a	3,728	
1,207	1,207	0	n/a	838	Carryforward	14,482	14,482	0	n/a	(576)	
73	73	0	n/a	(13)	Cafeteria	877	877	0	n/a	758	
200	200	0	n/a	246	Miscellaneous	2,400	2,400	0	n/a	2,610	
<u>15,365</u>	<u>15,365</u>	<u>0</u>	<u>n/a</u>	<u>14,344</u>	TOTAL NON-OPERATING REVENUE	<u>184,386</u>	<u>184,386</u>	<u>0</u>	<u>n/a</u>	<u>141,417</u>	
<u>(36)</u>	<u>(667)</u>	<u>631</u>	<u>94.6%</u>	<u>(561)</u>	NET INCOME/(LOSS)	<u>7,920</u>	<u>0</u>	<u>7,920</u>	<u>n/a</u>	<u>4,553</u>	

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/2002
Month Ending: FEB 28, 2002

CURRENT MONTH						YEAR-TO-DATE					
Actual	Budget	Variance	% Var	Prior Year		Actual	Budget	Variance	% Var	Prior Year	
KEY VOLUME INDICATORS											
<u>Discharges (incl. MHRF)</u>											
1,381	1,330	51	3.8%	1,329	Discharges (incl. MHRF)	11,422	11,382	40	0.4%	11,839	
1,932	1,857	75	4.0%	1,891	Adjusted Discharges (incl. MHRF)	15,876	15,959	(83)	-0.5%	16,673	
<u>Average Daily Census</u>											
189	184	5	2.4%	192	Acute Med/Surg ADC	192	179	13	7.3%	192	
90	92	(2)	-2.0%	92	Psych ADC	92	92	(0)	-0.1%	92	
28	21	7	31.9%	26	Skilled Nursing ADC	27	20	7	33.0%	23	
306	297	9	3.2%	310	Total ADC excl. MHRF	311	291	20	6.7%	307	
137	140	(3)	-2.4%	138	MHRF ADC	139	140	(1)	-0.9%	136	
443	437	6	1.4%	448	Total Adult ADC	449	431	18	4.2%	443	
8	7	1	8.6%	6	Nursery ADC	8	7	1	14.3%	6	
6.3	6.4	0.1	1.6%	6.6	Average Length of Stay (excl. MHRF)	6.7	5.9	(0.8)	-13.6%	6.4	
1,291	1,295	(0.004)	-0.3%	1,280	Medicare Case Mix Index	1,291	1,295	(0.004)	-0.3%	1,280	
<u>Payor Mix (Gross Revenue)</u>											
49.3%	48.5%	0.7%	1.5%	39.0%	Medi-Cal	45.7%	48.5%	-2.8%	-5.7%	44.4%	
18.7%	17.5%	1.2%	6.9%	20.9%	Medicare	17.5%	17.5%	0.0%	-0.1%	18.4%	
32.0%	33.9%	-1.9%	-5.7%	40.1%	Other	36.8%	34.0%	2.8%	8.2%	37.2%	
100.0%	100.0%	0.0%	n/a	100.0%	Total	100.0%	100.0%	0.0%	n/a	100.0%	
<u>Patient Days</u>											
5,375	4,361	1,014	23.3%	3,828	Medi-Cal Patient Days (excl. MHRF)	43,320	37,059	6,261	16.9%	38,928	
1,955	1,880	75	4.0%	2,342	Medicare Patient Days (excl. MHRF)	16,955	15,975	980	6.1%	17,115	
1,250	2,080	(830)	-39.9%	2,523	Other Patient Days (excl. MHRF)	15,204	17,678	(2,474)	-14.0%	18,487	
8,580	8,321	259	3.1%	8,693	Total Patient Days (excl. MHRF)	75,479	70,712	4,767	6.7%	74,530	
5,769	4,866	903	18.6%	4,293	Medi-Cal Patient Days	46,315	41,634	4,681	11.2%	43,998	
1,955	1,908	47	2.5%	2,342	Medicare Patient Days	16,955	16,323	632	3.9%	17,115	
4,681	5,467	(786)	-14.4%	5,923	Other Patient Days	45,927	46,772	(845)	-1.8%	46,484	
12,405	12,241	164	1.3%	12,558	Total Patient Days	109,197	104,729	4,468	4.3%	107,597	
17,354	17,095	259	1.5%	17,873	Adjusted Patient Days	151,750	146,857	4,893	3.3%	151,574	
82.5%	81.4%	1.1%	1.4%	83.6%	% Occupancy (available beds)	83.7%	80.3%	3.4%	4.2%	82.5%	
KEY OPERATIONAL INDICATORS											
<u>Labor</u>											
2,403.1	2,380.0	(23.1)	-1.0%	2,298.0	FTEs - Productive	2,364.9	2,380.0	15.1	0.6%	2,252.3	
308.0	329.0	21.0	6.4%	300.0	FTEs - Non-Productive	332.4	329.0	(3.4)	-1.0%	354.6	
2,711.1	2,709.0	(2.1)	-0.1%	2,598.0	Total FTEs - SFGH Only	2,697.3	2,709.0	11.7	0.4%	2,606.9	
334	334	0	n/a	334	UC Non-Academic FTEs	334	334	0	n/a	334	
3,045	3,043	(2)	-0.1%	2,932	Grand Total FTEs Incl. UC	3,031	3,043	12	0.4%	2,941	
4.9	5.0	0.1	2.0%	4.8	FTEs Per AOB (incl. UC)	4.9	5.0	0.2	3.0%	4.7	
\$ 63,740	\$ 60,126	(\$3,614)	-6.0%	\$60,634	Average Labor Cost per SFGH FTE	\$ 62,517	\$60,126	(\$2,391)	-4.0%	\$ 58,985	
24.0%	23.9%	-0.1%	-0.4%	26.7%	Fringe Benefits as % of Salary	24.0%	24.0%	0.0%	n/a	23.9%	
<u>Revenues</u>											
\$ 1,358	\$ 1,382	(\$24)	-1.7%	\$1,331	Oper. Rev. Per Adjusted Patient Day (incl. MHRF)	\$ 1,308	\$1,323	(\$15)	-1.1%	\$1,307	
\$ 652	\$ 655	(\$3)	-0.5%	\$618	Oper. Rev. (excl. SB855/1255/GME)/APD	\$ 661	\$646	\$15	2.3%	\$643	
\$ 12,202	\$ 12,721	(\$519)	-4.1%	\$12,581	Oper. Rev. Per Adjusted Discharge	\$ 12,503	\$12,177	\$326	2.7%	\$11,880	
\$ 5,853	\$ 6,027	(\$174)	-2.9%	\$5,843	Oper. Rev. (excl. SB855/1255/GME)/Adj. Discharge	\$ 6,322	\$5,946	\$376	6.3%	\$5,850	
<u>Expenses</u>											
\$ 2,246	\$ 2,160	(\$86)	-4.0%	\$2,126	Operating Exp. Per Adjusted Pt. Day	\$ 2,099	\$2,088	(\$11)	-0.5%	\$1,991	
\$ 1,789	\$ 1,681	(\$108)	-6.4%	\$1,668	Operating Exp.(excl. IGT)/Adj. Pt. Day	\$ 1,681	\$1,643	(\$38)	-2.3%	\$1,559	
\$ 20,174	\$ 19,881	(\$293)	-1.5%	\$20,092	Operating Exp. Per Adj. Discharge	\$ 20,065	\$19,218	(\$847)	-4.4%	\$18,098	
\$ 16,067	\$ 15,473	(\$594)	-3.8%	\$15,763	Operating Exp.(excl. IGT)/Adj. Discharge	\$ 16,066	\$15,115	(\$951)	-6.3%	\$14,170	
35.3%	32.4%	-2.9%	-9.0%	41.0%	Supply Expense as % of Net Pt. Revenue	31.3%	32.7%	1.4%	4.3%	35.6%	
88	80	(8)	-10.0%	107	Days Revenue in Accounts Receivable	88	80	(8)	-10.0%	107	

PI EDUCATION

PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS)

PIPS OVERVIEW

- ✓ JCAHO STANDARDS
- ✓ PIPS PROGRAM & PIPS COMMITTEE (P&P 17.1)
- ✓ ROLE OF COMMITTEES/STAFF
- ✓ SFGH PI METHODOLOGIES
- ✓ INDICATORS/PERFORMANCE MEASURES/ORYX
- ✓ PATIENT SAFETY PLAN

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PIPS PROGRAM JCAHO REQUIREMENTS

GO.2 Those responsible for Governance establish policy, promote performance improvement, and provide for organizational management and planning.

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PIPS PROGRAM JCAHO REQUIREMENTS

GO.2.1 The hospital's governing body or authority adopts bylaws addressing its legal accountabilities and responsibility to patient population served.

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PIPS PROGRAM GOVERNING BODY BYLAWS

WHEREAS, SFGH is a public hospital and a division of the Department of Public Health of the City and County of San Francisco; and

WHEREAS, the Charter of the City and County of San Francisco provides for a Health Commission charged with the management and control of the Department of Public Health and hospitals of the City and County of San Francisco; and

WHEREAS, the HC has adopted a Resolution accepting responsibility as the Governing Body of SFGH.

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PIPS PROGRAM GOVERNING BODY BYLAWS

ARTICLE III: ROLE AND PURPOSE OF THE HOSPITAL

The role and purpose, or mission, of the Hospital is to deliver humanistic, cost-effective and culturally-competent health services to the residents of the City and County of San Francisco through:

- A. A commitment to access for all residents by eliminating financial, linguistic, physical, and operational barriers;

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PIPS PROGRAM GOVERNING BODY BYLAWS

- B. The provision of quality services that treat illness, promote and sustain wellness, and prevent the spread of disease, injury, and disability;
- C. Participation in and support of training and research efforts; and
- D. Commitment to community involvement in meeting healthcare needs.

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PIPS PROGRAM

The SFGH Performance Improvement and Patient Safety (PIPS) Program is described in the Hospital-wide P&P 17.1

The PIPS P&P was approved at the SFGHMC annual meeting held on December 4, 2001.

PIPS PROGRAM

(P&P 17.1)
PURPOSE

Systematically monitor, analyze, and improve processes to improve patient care outcomes and patient safety. The PIPS P&P defines the organization-wide process for performance improvement.

PIPS COMMITTEE STRUCTURE OF THE PIPS COMMITTEE

The PIPS Committee is a medical staff committee. The medical staff has charged the PIPS Committee with implementing the organization-wide performance improvement patient safety programs.

The Committee is co-chaired by Dr. John Luce, Medical Director of Quality Management, and Hiro Tokubo, Director of Quality Management.

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PIPS COMMITTEE STRUCTURE OF THE PIPS COMMITTEE

The Committee has a physician representative from:

- Anesthesia, Emergency Medicine, Family and Community Medicine, Medicine, Neurology, Obstetrics and Gynecology, Orthopedics, Pediatrics, Psychiatry and Surgery.

PIPS COMMITTEE STRUCTURE OF THE PIPS COMMITTEE

In addition, one representative from Radiology, Clinical Lab, Pharmacy, Infection Control and Nursing.

Committee members also include:

Associate Administrators

Administrative Director of Utilization Management

PIPS COMMITTEE CHARGE OF THE PIPS COMMITTEE

The PIPS Committee takes an interdisciplinary and proactive approach in the prevention of adverse events, medical errors and near misses and promotes patient outcomes/safety as the core value in providing quality patient care.

PIPS COMMITTEE CHARGE OF THE PIPS COMMITTEE

- ✓ It focuses on performance improvement activities related to major aspects of the care, and clinical process/outcome/safety indicators.
- ✓ It facilitates a multidisciplinary, interdepartmental, collaborative approach to improving the quality of patient care and safety.

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PIPS COMMITTEE OVERSIGHT OF MEDICAL STAFF COMMITTEES/SUBCOMMITTEES

The following medical staff committees and subcommittees reports to PIPS:

- ✓ Code Blue Subcommittee
- ✓ Diagnostic Services Subcommittee
- ✓ Medical Record Review Subcommittee

PIPS COMMITTEE OVERSIGHT OF MEDICAL STAFF COMMITTEES/SUBCOMMITTEES

- ✓ Patient Concern Subcommittee
- ✓ Pediatric Emergency Medicine Subcommittee
- ✓ Risk Management Subcommittee
- ✓ Tissue Subcommittee
- ✓ Transfusion Subcommittee
- ✓ Trauma Performance Improvement Subcommittee

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PIPS COMMITTEE MONITORING AND REPORTING FUNCTIONS

- ✓ Ensures appropriate review, analysis and follow-up of performance improvement opportunities.
- ✓ Reports and forwards recommendations monthly to Medical Executive Committee through the Medical Director of Quality Management
- ✓ Reports and forwards recommendations quarterly to the Governing Body/JCC through the Medical Director of Quality Management

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PIPS COMMITTEE RECOMMENDATIONS TO HOSPITAL EXECUTIVE COMMITTEE

PIPS recommends performance improvement activities according to potential impact upon patient outcomes and safety.

Dr. Luce presents recommendations during his monthly quarterly/risk/patient safety report.

PIPS COMMITTEE

SFGH EXECUTIVE COMMITTEE'S ROLE IN THE PIPS PROGRAM

- ✓ Develops, reviews & approves policies concerning performance improvement, quality of care & patient safety.
- ✓ SFGH Executive Committee identifies, prioritizes, implements, and evaluates opportunities to improve organizational functions and systems
- ✓ It designates PI Task Forces.

JCC/SFGH

PIPS COMMITTEE

THE GOVERNING BODY'S ROLE IN THE PIPS PROGRAM

The SFGH JCC and the SF Health Commission are ultimately responsible for maintaining the quality of patient care and safety.

- ✓ Establish/Approve policies (P&P 17.1)
- ✓ Regularly reviews PI & patient safety reports (Drs. Navarro & Luce present monthly reports to the SFGH JCC).
- ✓ On an annual basis, a quality report is presented to SF Health Commission

JCC/SFGH

PIPS PROGRAM

(P&P 17.1)

SFGH PI METHODOLOGIES

- ✓ FOCUS-PDCA is the PI model that SFGH uses for its PI Task Forces.
- ✓ FMEA/FMECA, or Failure, Mode, Effects and Criticality Analysis methodology is utilized to perform proactive risk assessments.

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PIPS PROGRAM FOCUS-PDCA

FIND A PROCESS TO IMPROVE

↓

ORGANIZE TO IMPROVE THE
PROCESS

↓

CLARIFY CURRENT KNOWLEDGE OF
THE PROCESS

↓

UNDERSTAND SOURCES OF THE
PROCESS VARIATION

↓

SELECT THE PROCESS
IMPROVEMENT

ORGANIZATIONAL IMPROVEMENT SUMMARY

Project Name: Bed Utilization
Team Leader/Chair: Rita Smith, RN
Date: 2000

IMPROVEMENT PROJECT STEPS	SUMMARY
<p>F</p> <p>Find a process to improve. How is the improvement project identified? Who are the customers? What benefits are expected? Attach the opportunity statement and teaming letter.</p>	<p>• An opportunity exists to improve the patient care at SFGH by better pre-admission management of bed utilization during "crunch" periods. It is important to work on this issue now because bedside critical care services have been threatened as of August 2000. The goal of the group was to ensure that SFGH has a system that allows for timely admission of patients. A suggested solution of this is that 5 or fewer patients are waiting in the ED in its morning for a bed. Three committees would need to be formed in order to fulfill its goal. Do we have adequate and appropriate resources to move the patient through the system efficiently? Do we have adequate beds to care for our patients? Are we discharging our patients early enough and if not, what?</p>
<p>O</p> <p>Organize to improve the process. Who on the team are to be held, their responsibilities, and department who are the knowledge expert? Who is the process owner? Who is the chairperson and facilitator? Attach process improvement plan including general timeline.</p>	<p>A multidisciplinary team consisting of the following disciplines was organized:</p> <ul style="list-style-type: none"> • Administration • Physicians • Nursing Administration • ICU Nurses • ED Nurses • Med/Surg Nurses • Pharmacy • Respiratory • Primary Care Nurses • PACU/ICU Nurses • Simulation Management • Quality Management

<p style="text-align: center;">C</p> <p>Clarify current knowledge of the process. What is the current flow of the process? Were there any weak and easy to improve? Attach flowcharts and other data which clarify the current process.</p>	<p>Our current situation started at high occupancy rates, low staffing levels, inability to admit to the Progressive Care Unit, and back up of patients in ED, OR, ICU, PACU. The Housestaff performed to maintain their patients on the Progressive Care Unit until they were more comfortable with the patient's stability. The rest of our attention on these scarce beds. Many of our homeless patients stayed in the hospital until late on the day of discharge requiring a bed in one of the shelters. Discharge is sometimes made a long period of time to get to the unit.</p>
<p style="text-align: center;">U</p> <p>Understand sources of process variation. What are the potential process variation identified? How are the variations prioritized? Attach graphs, tables, and other data which demonstrates the process variations.</p>	<p>There was no identified critical gap-keeper in the Progressive Care Unit. The highest occupancy period was 13:00 to 23:00 and discharges occurred late in the afternoon. The delays in getting patient's discharge medications in a timely fashion were found to be a lack of delivery system in the room. The Department of Medicine Teaching Rounds were scheduled early in the day and the Housestaff was delayed in writing discharge orders or making patient rounds. Though our Hospital P&P called for a written discharge order by 15:00 our orders were written in the afternoon. There was no system in place to notify all of the involved staff of the occurrence of the bed "crunch" when it occurred. Because most of our patients were being discharged late in the afternoon, late-charging was not any trouble keeping up with the patient data and for these beds.</p>
<p style="text-align: center;">S</p> <p>Select the process improvement. What actions will be used to evaluate the improvement? Attach primary list.</p>	<p>A team began looking for patients to use for discharge in education, right home, level beds, etc. was developed. An organized system to alert the staff involved in the discharge/assessment of a patient during time of use was bed change was developed.</p>

<p>P</p> <p>Place the information on the form in the following order: Patient's name, date, time, place, and date the information was received. If the information is from a patient, place the patient's name in the space provided.</p>	<p>Place the information on the form in the following order: Patient's name, date, time, place, and date the information was received. If the information is from a patient, place the patient's name in the space provided.</p>
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<p>PIPS PROGRAM</p> <p>STAFF ROLES AND RESPONSIBILITIES</p> <p>The responsibility for providing quality services is shared by all staff, including the medical staff:</p> <ul style="list-style-type: none"> ✓ Assist in identifying opportunities for improvements ✓ Participate in performance improvement and patient safety activities ✓ Report medical health care errors and near misses <p>3/12/02 JCS/SFOH</p>

<p>PIPS</p> <p>INDICATORS/ PERFORMANCE MEASURES/ ORYX</p>

<p>PIPS COMMITTEE</p> <p>DATA SOURCES</p> <p>The PIPS Committee identifies organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data:</p> <ul style="list-style-type: none"> □ Medication errors including near misses □ Adverse Drug Reactions

<p>PIPS COMMITTEE</p> <p>DATA SOURCES</p> <ul style="list-style-type: none"> □ Patient care review □ Patient, family and staff satisfactory surveys □ Utilization review data □ Patient/visitor concerns □ Clinical service and ancillary/diagnostic Department performance improvement reports □ Ongoing medical record review

<p>PIPS COMMITTEE</p> <p>DATA SOURCES</p> <ul style="list-style-type: none"> □ Quality control reports from clinical labs, diagnostic radiology, dietetic services, nuclear medicine □ Unusual Occurrence reports □ Restraints and seclusion use □ ORYX Indicators □ Outcomes related to resuscitation □ Mortality and autopsy results <i>heavier emphasis</i> □ Infection control surveillance
--

JCAHO AND PIPS ORYX

WHAT IS ORYX?

ORYX is the name of the JCAHO initiative to integrate performance measurement into the accreditation process. It allows JCAHO to review data trends and patterns on selected indicators for each accredited hospital and assess how the data is used to improve patient care.

JCAHO/PIPS/ORYX

What are the SFGHMC ORYX Indicators?

The current indicator transmitted to JCAHO are:

- ✓ Patient Mortality in the Cardiology Product line
- ✓ All C-Sections
- ✓ Patient readmitted with a psychiatric principal diagnosis less than 15 days after discharge for a psychiatric condition

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JCAHO/PIPS/ORYX

- ✓ Patient Mortality in the Trauma Product Line
- ✓ Length of Stay (LOS) for patients w/simply pneumonia & pleurisy with complication and and/or comorbidities
- ✓ LOS for HIV patients with major related condition
- ✓ LOS for patient's in the Trauma Product Line
- ✓ LOS for Pediatric patients with asthma

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JCAHO/PIPS/ORYX

What do we do with ORYX reports?

Quarterly ORYX reports are distributed to Chiefs of Service in departments with relevance to one or more indicators.

Trends in ORYX data are reviewed through the Performance Improvement and Patient Safety Committee.

Data from ORYX reports serve to guide performance improvement projects, as appropriate.

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JCAHO/PIPS/ORYX

What are some examples of use of ORYX data for performance improvement?

- ✓ Pneumonia LOS indicators results were used to initiate further internal analysis and interdepartmental PI project related to pneumonia treatment
- ✓ Psychiatry Readmission reports were used to conduct an evaluation of the accuracy of re-admission data.

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PIPS PROGRAM PATIENT SAFETY PROGRAM

- ✓ In July 2001, new JCAHO standards concerning patient safety and reduction of medical errors were into effect. A Task Force, co-chaired by John Kanaley and Allison Moed, presented the SFGH Patient Safety Plan to Executive Committee in July 2001
- ✓ SFGH JCC approved the Patient Safety Plan

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PIPS PROGRAM

PATIENT SAFETY PROGRAM

With the approval of the plan, the Quality Utilization Management Committee became the oversight body for the patient safety plan. QUM changed its name to Performance Improvement and Patient Safety and expanded its membership to deal with the expanded functions.

3/12/01 KC/SPH

PIPS PROGRAM

PATIENT SAFETY PROGRAM

With the approval of the plan, the Quality Utilization Management Committee became the oversight body for the patient safety plan. QUM changed its name to Performance Improvement and Patient Safety and expanded its membership to deal with the expanded functions.

3/12/01 KC/SPH

W1202.

ИСПЫТАНИЕ

PIPS PROGRAM

PATIENT SAFETY PROGRAM

PIPS was assigned the responsibility to select a hi-risk process for FMEA (Failure Mode, Effects, Analysis) analysis.

PIPS was assigned the responsibility to administer a survey tool to assess the culture of reporting medical errors. The tool has been finalized and will be administered during March

Education of staff, physician and leadership regarding PIPS. DET to incorporate patient safety into staff orientation and employee evaluations.

- # PIPS PROGRAM
- ## PATIENT SAFETY PROGRAM
- PIPS was assigned the responsibility to select a hi-risk process for FMEA (Failure Mode, Effects, Analysis) analysis.
- PIPS was assigned the responsibility to administer a survey tool to assess the culture of reporting medical errors. The tool has been finalized and will be administered during March
- Education of staff, physician and leadership regarding PIPS. DET to incorporate patient safety into staff orientation and employee evaluations.

[illegible]

Patient Safety and Medical Error Reduction Task Force											
Project Timeline											
	Task Name	Start Date	End Date	Duration	Progress	1	2	3	4	5	6
1	Boarding Quarterly Board Meeting	9/24/09	9/24/09	1 day	100%						
2	Survey Standard	9/24/09	9/24/09	1 day	100%						
3	Forming Peer-Sent Committee to Assess RRT (Temporary Safety, Communication, Emergency Call)	9/24/09	10/2/09	9 days	100%						
4	Present in Place to Inform Patients About Concerns of Care via PAFs (Safety Concern Feedback Panel)	10/2/09	10/2/09	1 day	100%						
5	QMR to Review Concepts Being PAFs (Safety Concern Feedback Panel)	10/2/09	10/2/09	1 day	100%						
6	PAF to Review Patient Pressure for "Safety Concern" Analysis for 2009/09	10/2/09	10/2/09	1 day	100%						
7	PAF to Review Data for Incident in Progress	10/2/09	11/24/09	53 days	100%						
8	PAF to Review Development/Implementation of "Safety" Assessment Tool	10/2/09	11/24/09	53 days	100%						
9	PAF to Review All incidents of PAF, Safety issues in Staff Education & Assessment, Patient Education	11/24/09	12/24/09	31 days	100%						
10	Quarterly Report on Progress to the Board/PAF (Q2)	12/24/09	12/24/09	1 day	100%						

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City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

0.458
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President

Roma P. Guy, M.S.W.
Vice President

Arthur M. Jackson
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CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor
Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, April 9, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

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Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF MARCH 12, 2002
**Minutes of March 12, 2002*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGHMC)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Officer)
**Report*
- 5) FOR DISCUSSION: FINANCE REPORT - STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
**Report*

- 6) **FOR DISCUSSION:** **ORGANIZATIONAL EFFECTIVENESS ASSESSMENT REPORT**
(Gene Marie O'Connell, Executive Administrator)
**Report*

7) **PUBLIC COMMENT****

8) **CLOSED SESSION**

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **APPROVAL OF CLOSED SESSION MINUTES OF FEBRUARY 12, 2002**

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE**

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: **CONSIDERATION OF CREDENTIALING MATTERS**
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION: **MEDICAL STAFF REPORT**
J. Renee Navarro, M.D., Chief of Staff

- D) Reconvene in Open Session
1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
 2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

9) **ADJOURNMENT**

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

* Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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1/02
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Vice President

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Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

Tel. (415) 554-2666
FAX (415) 554-2665

Web Site: <http://www.dph.sf.ca.us>

MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, April 9, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

MAY 9 2002

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1) CALL TO ORDER

The San Francisco General Hospital Joint Conference Committee meeting was called to order by Commissioner Lee Ann Monfredini at 4:00 p.m.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner Edward A. Chow, M.D.

Absent: Commissioner John I. Umekubo, M.D.

Staff: Rod Auyang, Sharon Calcagno, Wahid Choudhury, Doug Eckman, Mozettia Henley, John Kanaley, Judith Klain, Sharon Kotabe, Pharm.D., Alyssa Leong, John Luce, M.D., Allison Moed, Kathy Murphy, J. Renee Navarro, M.D., Gene O'Connell, Patricia Perez-Arce, Ph.D., Roland Pickens, Gregg Sass, Hiro Tokubo, Chris Wachsmuth, Connie Young

2) APPROVAL OF MINUTES OF MARCH 12, 2002

Action Taken: The Committee approved the minutes from the March 12, 2002 San Francisco General Hospital Joint Conference Committee.

3) HOSPITAL HEALTHCARE UPDATE

Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center, presented the Hospital Healthcare Update.

Program Updates

DHS Unannounced Annual Licensing and Certification Survey of Skilled Nursing Facilities
Last Tuesday, April 2nd, the local Department of Health Services performed their annual unannounced licensing and certification survey of both the 4A Skilled Nursing Facility and the Mental Health Rehabilitation Facility (MHRF). The survey spanned four (4) days concluding on Friday, April 5th early afternoon. Preliminary results provided at the exit conference indicate that the surveyors did not find any quality of care-related deficiencies. Over the following months, a formal statement of findings is expected from DHS and SFGH will update the JCC-SFGH.

Congratulations to Mozettia Henley and Sue Currin and their staff for their leadership and success in the survey!

Civil Grand Jury's Recommendation to Rebuild SFGH

On Tuesday, April 2nd the Civil Grand Jury of the Superior Court of California, County of San Francisco, issued a report recommending that the City and County of San Francisco rebuild San Francisco General Hospital (SFGH) and introduce a bond measure that has the greatest chance of voter approval.

As reported over the two years to the Health Commission, SFGH does not meet California seismic codes and in order to comply with SB 1953, must rebuild by 2013 or face closure in the year 2008.

The Executive Committee is pleased with the recommendations by the Civil Grand Jury and looks forward to the responses by the Health Commission, Mayor's Office, and the Board of Supervisors to the Civil Grand Jury, as requested by the Civil Grand Jury's report.

Audit of SFGH by the Board of Supervisors' Budget Analyst

Over the next couple of weeks, Harvey Rose, Budget Analyst for the Board of Supervisors, will be performing an audit of San Francisco General Hospital Medical Center. The audit was requested by the Board of Supervisors in January 2001 through the adoption of Motion M01-1 approving a schedule of audits to be conducted by the Budget Analyst of programs of City and County departments. Over the year, the scope of the audit has decreased from the entire Department of Public Health to solely San Francisco General Hospital Medical Center.

As part of the audit, Harvey Rose and his staff will be requesting interviews from key personnel at SFGHMC. At the time of Mr. Rose's initial request, the SFGH offices had requested that the interviews take place after the upcoming JCAHO survey; however his office feels that the audit must be undergone now and cannot be delayed. All of the requests for interviews have been coordinated through Wahid Choudhury, Controller for SFGHMC; and Gregg Sass, Chief Financial Officer. The areas which they will be focusing on include: Coding, Billing, Eligibility, Utilization Review, Risk Management, Compliance, Medical Records Management, Billing/Revenue Collection Practices, Annual/Ongoing development of revenue estimates and tracking of actuals, Billing rates, staffing and implementation of staffing ratios and acuity model,

expenditures, reserve requirement policies/cost reports, UCSF Contract, materials management, and pharmacy operations.

SFGH will continue to update the JCC-SFGH as the audit continues.

4) **PATIENT CARE REPORT**

Sue Currin, RN, Chief Nursing Officer, presented the patient care report (Attachment A).

5) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**

Gregg Sass, CHN Chief Financial Officer, presented the March 2002 Finance Report (Attachment B).

6) **ORGANIZATIONAL EFFECTIVENESS ASSESSMENT REPORT**

Gene O'Connell distributed the Organizational Effectiveness Assessment Report (Attachment C).

7) **PUBLIC COMMENT**

None.

8) **CLOSED SESSION**

A) **Public Comments on All Matters Pertaining to the Closed Session**

None.

B) **Vote on Whether to Hold a Closed Session**

Action Taken: The Committee voted to hold a closed session.

The Committee went into closed session at 5:05 p.m. Present in closed session were those present in open session.

C) **Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1**

APPROVAL OF CLOSED SESSION MINUTES OF FEBRUARY 12, 2002

Action Taken: The Committee approved the closed session minutes of February 12, 2002.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

CONSIDERATION OF CREDENTIALING MATTERS

Action Taken: The Committee approved the Credentials Report.

MEDICAL STAFF REPORT

D) Reconvene in Open Session

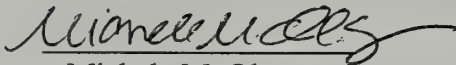
The Committee reconvened in open session at 5:45 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in closed session.

9) ADJOURNMENT

The meeting was adjourned at 5:45 p.m.



Michele M. Olson
Executive Secretary to
the Health Commission

Attachment (3)

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 4/9/02

Sue Currin, RN, MS, Chief Nursing Officer

1. Universal Newborn Hearing Screening

In January 1998, Universal Newborn Hearing Screening (AB 2780) became law, mandating a newborn screening program to provide early detection, diagnosis, and follow-up of hearing problems. The California Children's Services (CCS) requires all CCS approved hospitals with licensed perinatal services and neonatal intensive care units to comply with Universal Newborn Hearing Screen Program by January 1, 2003.

In addition to being part of the beta test program in 1997, SFGHMC completed the certification process on the 15th of March 2002 making our facility the 4th out of 44 hospitals and Hearing Coordination Centers to achieve this certification.

2. Nursing Leadership Development

The first steps of the SFGHMC's integrated strategic leadership development process (mission/values/vision, strategies/scorecard/action plan, and team effectiveness) began with senior management retreats in the fall of 2001, and has been replicated with divisional leadership teams.

The steps of the process involving identification of leadership competencies were begun via the participation of nursing clinical leaders in a national research project, *The Nursing Leadership Edge*. The nursing clinical leaders identified ten top leadership competencies that are critical to individuals holding SFGHMC positions. The competencies include:

- Employee Development/ Coaching
- Interpersonal Skill
- Empathy
- Teamwork
- Self-management
- Flexibility
- Planning/ Organizing
- Conflict Management
- Diplomacy
- Goal Orientation

Through this process, the nursing clinical leadership identified that understanding, appreciating and adapting communication/learning styles are key to team effectiveness. The nursing clinical leadership competency profiles, development plans and training programs that derive from this research will ensure that SFGHMC's recruitment, retention, development and continuing education are oriented toward the hospital's mission, vision and staff development priorities.

2. Restraints

The plan for performance improvement monitoring for restraint usage includes daily monitoring of all restraint usage throughout SFGH in the areas which utilize restraint: the Emergency Department, Critical Care, Medical-Surgical, PES and Acute Psychiatry. The daily monitoring allows an "in the moment" ability to improve patient care related to restraint as well as improvements in documentation. Additionally, nursing staff can be engaged in an educational process related to restraint usage. On a daily basis, the House Supervisor monitors the number of patients restrained, the presence and accuracy of physician orders, and the nursing assessment, monitoring and evaluation of restraint usage. The Nurse Managers are responsible for daily follow-up of monitoring with the nursing staff. Monitoring for 2002 also includes monthly prevalence data on patients in restraints, including restraint duration. This data is collated quarterly.

In Acute Psychiatry, additional monitoring is mandated by JCAHO Behavioral Health standards. The monitoring includes unit specific data collection on the shift of restraint initiation, provider initiating restraint, day of week, date of month, restraint episodes greater than 12 hours, 3 or more episodes in 12 hours, age, sex, gender of patient; interventions, length of time in restraints, trending of unit use.

3. Diversion Summary Report

See attached.

PTCARE 4-9-02

San Francisco General Hospital

Diversion Report

March 2002

Executive Summary

The Emergency Department [ED] recorded 36 episodes of diversion for 221.5 hours representing a rate of 29.8% in **March 2002**. This is a 15.4% decrease in diversion since **February 2002**.

The 36 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from Previous Month
Total Diversion	36	221.5	29.8	15.4%
Trauma Override	5	14	1.9%	8%

The ED was impacted by capacity and high patient acuity during the episodes of Total Diversion and Trauma Override. During this time, 213 patients were awaiting admission to in-patient beds [ICU-11, 4B/StepDown-64, MedSurg-138]. **In March 2001, the ED was on diversion 22% of the month. Trauma Override was invoked 1.5% of the month in March 2001.**

Total Diversion was recorded for 36 episodes, a total of 221.5 hours or a 29.8% rate for March 2002. While on Total Diversion the ED held 213 patients.

Trauma Override was recorded for 5 episodes, a total of 14 hours or a 1.9% rate for March 2002. This is an 8% decrease in Trauma Override from February 2002. While on Trauma Override the ED held 29 patients awaiting inpatient beds.

Definitions:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSS definitions:

Total diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Sharon Kennedy R.N.
Base Hospital Coordinator

San Francisco General Hospital
Emergency Department
March 2002
Total Diversion Summary

In March 2002, the Emergency Department recorded 36 episodes of Total Diversion for 221 hours and 30 min, a percentage of 29.8% for the month.

Date	Length	Summary of Event
03/01/02	2008-2235 (2h 27m)	31 patients in the ED Admits: 1-4B, 2-Floor Fast Track: Open ED waiting room: 4 urgent patients
03/02/02	1745-2130 (3h 45m)	27 patients in the ED Admits: 2-4B; 11-Floor Fast Track: Closed ED waiting room: 8 urgent patients
03/04/02	1225-2005 (7h 40m)	39 patients in the ED Admits: 1-4B; 2-Floor Fast Track: Open ED waiting room: 6 urgent patients
03/04/02	2205-0430 (6h 25m)	32 patients in the ED Admits: 2-4B; 5-Floor Fast Track: Open ED waiting room: 1 urgent patients
03/06/02	1455-1855 (4h)	35 patients in the ED Admits: 1-4B; 5-Floor Fast Track: Open ED waiting room: 8 urgent patients
03/06/02	2230-0135 (3h 5m)	30 patients in the ED Admits: 3-4B; 2-Floor Fast Track: Closed ED waiting room: 3 urgent patients
03/07/02	1445-0248 (12h 3m)	34 patients in the ED Admits: 4-4B; 1-Floor Fast Track: Open ED waiting room: 5 urgent patients
03/08/02	1305-1345 (40m)	49 patients in the ED Admits: 1-ICU, 3-Floor Fast Track: Closed ED waiting room: 3 urgent patients
03/08/02	1600-0440 (12h 40m)	33 patients in the ED Admits: 2-4B; 2-Floor Fast Track: Open ED waiting room: 10 urgent patients
03/09/02	1650-2200 (5h 10m)	35 patients in the ED Admits: 1-4B; 4-Floor Fast Track: Closed ED waiting room: 6 urgent patients
03/11/02	1410-1815 (4h 5m)	38 patients in the ED Admits: 7-4B; 1-Floor Fast Track: Open ED waiting room: 8 urgent patients
03/12/02	1835-0533 (10h 58m)	34 patients in the ED Admits: 3-4B; 4-Floor Fast Track: Open ED waiting room: 10 urgent patients

03/13/02	1230-2240 (10h 10m)	43 patients in the ED Admits: 1-ICU; 2-4B; 3-Floor Fast Track: Open ED waiting room: 5 urgent patients
03/15/02	1054-1228 (1h 32m)	39 patients in the ED Admits: 2-ICU; 1-4B; 7-Floor Fast Track: Open ED waiting room: 3 urgent patients
03/15/02	1710-0615 (13h 5m)	36 patients in the ED Admits: 2-4B; 4-Floor Fast Track: Open ED waiting room: 12 urgent patients
03/16/02	1730-2200 (4h 30m)	34 patients in the ED Admits: 4-4B; 4-Floor Fast Track: Open ED waiting room: 2 urgent patients
03/17/02	1350-1800 (4h 10m)	36 patients in the ED Admits: 3-4B; 1-Floor Fast Track: Open ED waiting room: 5 urgent patients
03/17/02	2200-0615 (8h 15m)	29 patients in the ED Admits: 1-4B; 7-Floor Fast Track: Closed ED waiting room: 10 urgent patients
03/18/02	1430-0442 (14h 12m)	37 patients in the ED Admits: 1-4B; 3-Floor Fast Track: Open ED waiting room: 11 urgent patients
03/19/02	1132-1840 (7h 8m)	30 patients in the ED Admits: 1-4B; 7-Floor Fast Track: Open ED waiting room: 6 urgent patients
03/19/02	1945-2045 (1h)	39 patients in the ED Admits: 2-4B; 5-Floor Fast Track: Closed ED waiting room: 0 urgent patients
03/19/02	2125-2240 (1h 15m)	25 patients in the ED Admits: 1-ICU; 2-4B; 4-Floor Fast Track: Closed ED waiting room: 0 urgent patients
03/20/02	1450-0345 (12h 55m)	29 patients in the ED Admits: 3-4B; 4-Floor Fast Track: Open ED waiting room: 9 urgent patients
03/21/02	1353-1830 (4h 37m)	33 patients in the ED Admits: 1-ICU; 1-4B; 7-Floor Fast Track: Closed ED waiting room: 5 urgent patients
03/22/02	1045-1325 (2h 40m)	38 patients in the ED Admits: 1-4B; 2-Floor Fast Track: Open ED waiting room: 2 urgent patients
03/23/02	0100-0630 (5h 30m)	40 patients in the ED Admits: 4-4B; 5-Floor Fast Track: Closed ED waiting room: 13 urgent patients
03/23/02	1800-2100 (3h)	32 patients in the ED Admits: 6-Floor Fast Track: Closed ED waiting room: 0 urgent patients
03/24/02	1725-0105 (5h 40m)	33 patients in the ED Admits: 2-4B; 3-Floor Fast Track: Open ED waiting room: 5 urgent patients

03/25/02	1250-2300 (10h 10m)	38 patients in the ED Admits: 2-4B Fast Track: Open ED waiting room: 5 urgent patients
03/26/02	1535-2100 (5h 25m)	38 patients in the ED Admits: 1-ICU; 1-4B; 2-Floor Fast Track: Closed ED waiting room: 10 urgent patients
03/27/02	1035-1845 (8h 10m)	20 patients in the ED Admits: 1-ICU; 9-Floor Fast Track: Open ED waiting room: 0 urgent patients
03/27/02	2220-0255 (4h 35m)	35 patients in the ED Admits: 1-ICU; 1-4B; 4-Floor Fast Track: Closed ED waiting room: 10 urgent patients
03/28/02	1432-0305 (12h 33m)	35 patients in the ED Admits: 1-ICU; 2-4B; 2-Floor Fast Track: Open ED waiting room: 5 urgent patients
03/29/02	1305-1700 (3h 5m)	31 patients in the ED Admits: 5-Floor Fast Track: Closed ED waiting room: 0 urgent patients
03/30/02	0316-0630 (3h 14m)	35 patients in the ED Admits: 1-4B; 2-Floor Fast Track: Closed ED waiting room: 12 urgent patients
03/31/02	1035-1215 (1h 40m)	33 patients in the ED Admits: 1-ICU Fast Track: Open ED waiting room: 4 urgent patients

San Francisco General Hospital
Emergency Department
March 2002
Trauma Override Summary

The Emergency Department recorded 5 episodes of Trauma Override for 14 hours, a percentage of 1.9% for the month of March 2002.

Date	Length	Summary of Event
03/01/02	2032-2230 (1h 58m)	911-2 912-8 910-1
03/04/02	1400-1700 (3h)	911-0 912-2 910-0
03/07/02	1545-1645 (1h)	911-1 912-3 910-0
03/11/02	1510-1620 (1h 10m)	911-0 912-2 910-0
03/11/02	1840-0145 (7h 5m)	911-0 912-2 910-0

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/2002

Month Ending: MAR 31, 2002

(In Thousands of Dollars)

MONTHLY						ANNUAL					
Fav/(Unfav)						Fav/(Unfav)					
Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual	
GROSS PATIENT REVENUE:											
1	18,626	14,779	3,847	26.0%	13,564	Inpatient Medi-Cal Revenue	191,453	171,999	19,454	11.3%	153,288
2	4,436	4,820	(384)	-8.0%	4,529	Outpatient Medi-Cal Revenue	50,195	56,751	(6,556)	-11.6%	50,578
3	6,006	5,183	823	15.9%	5,353	Inpatient Medicare Revenue	67,671	60,321	7,350	12.2%	63,264
4	2,097	1,897	200	10.5%	2,257	Outpatient Medicare Revenue	23,743	22,337	1,406	6.3%	23,428
5	6,835	8,904	(2,069)	-23.2%	10,516	Inpatient Other Revenue	114,831	103,635	11,196	10.8%	117,606
6	6,211	4,787	1,424	29.7%	5,852	Outpatient Other Revenue	72,235	56,365	15,870	28.2%	63,963
7											
8	<u>44,211</u>	<u>40,370</u>	<u>3,841</u>	<u>9.5%</u>	<u>42,071</u>	TOTAL PATIENT SERVICE REVENUE	<u>520,128</u>	<u>471,408</u>	<u>48,720</u>	<u>10.3%</u>	<u>472,127</u>
9											
REVENUE DEDUCTIONS:											
11	4,315	6,687	2,372	35.5%	6,637	Charity Care	61,881	76,680	14,799	19.3%	80,879
12	16,673	15,006	(1,667)	-11.1%	7,782	Provision for Medi-Cal Adjustments	186,854	175,229	(11,625)	-6.6%	151,423
13	4,281	2,547	(1,734)	-68.1%	5,077	Provision for Medicare Adjustments	48,285	29,737	(18,548)	-62.4%	41,734
14	4,832	4,030	(802)	-19.9%	12,506	Provision for Other Adjustments	69,345	48,463	(20,882)	-43.1%	60,550
15	1,875	2,098	223	10.6%	1,917	Provision for Bad Debt	22,500	24,500	2,000	8.2%	19,021
16	<u>31,976</u>	<u>30,368</u>	<u>(1,608)</u>	<u>-5.3%</u>	<u>33,919</u>	TOTAL REVENUE DEDUCTIONS	<u>388,865</u>	<u>354,609</u>	<u>(34,256)</u>	<u>-9.7%</u>	<u>353,607</u>
17											
18	<u>12,235</u>	<u>10,002</u>	<u>2,233</u>	<u>22.3%</u>	<u>8,152</u>	NET PATIENT SERVICE REVENUE	<u>131,263</u>	<u>116,799</u>	<u>14,464</u>	<u>12.4%</u>	<u>118,520</u>
19											
OTHER OPERATING REVENUE:											
21	710	710	0	n/a	1,038	Capitation/Managed Care Settlement	8,519	8,519	0	n/a	10,124
22	46	421	(375)	-89.1%	388	Short Doyle	4,554	5,054	(500)	-9.9%	4,654
23	11,778	10,515	1,263	12.0%	10,626	SB855	127,867	126,183	1,684	1.3%	104,112
24	1,642	1,808	(166)	-9.2%	1,833	SB1255	19,700	21,700	(2,000)	-9.2%	22,000
25	108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300
26	594	660	(66)	-10.0%	830	Revenue from Other City Departments	7,132	7,924	(792)	-10.0%	9,391
27	1,049	0	1,049	n/a	0	Prior Year Settlement	1,411	0	1,411	n/a	(4,556)
28	333	365	(32)	-8.8%	667	MAA & Other Net Patient Revenue	4,000	4,381	(381)	-8.7%	4,085
29	<u>16,260</u>	<u>14,587</u>	<u>1,673</u>	<u>11.5%</u>	<u>15,490</u>	TOTAL OTHER OPERATING REVENUE	<u>174,483</u>	<u>175,061</u>	<u>(578)</u>	<u>-0.3%</u>	<u>151,110</u>
30											
31	<u>28,495</u>	<u>24,589</u>	<u>3,906</u>	<u>15.9%</u>	<u>23,642</u>	TOTAL OPERATING REVENUE	<u>305,746</u>	<u>291,860</u>	<u>13,886</u>	<u>4.8%</u>	<u>269,630</u>
32											
OPERATING EXPENSES:											
34	13,940	13,582	(358)	-2.6%	12,788	Personnel Services	168,568	162,986	(5,582)	-3.4%	154,242
35	3,342	3,257	(85)	-2.6%	2,364	Mandatory Fringe Benefits	40,418	39,079	(1,339)	-3.4%	37,020
36	8,608	8,358	(250)	-3.0%	8,294	Contractual Services	103,300	100,300	(3,000)	-3.0%	91,788
37	3,225	2,100	(1,125)	-53.6%	2,148	Materials and Supplies (excl. Pharm.)	26,705	25,205	(1,500)	-6.0%	25,582
38	42	1,167	1,125	96.4%	1,100	Pharmaceuticals	12,500	14,000	1,500	10.7%	12,621
39	605	630	25	4.0%	507	Facilities Maintenance & Capital Outlay	7,262	7,562	300	4.0%	3,173
40	1,393	1,455	62	4.3%	190	Services of Other Departments	15,769	17,461	1,692	9.7%	15,135
41	(99)	(110)	(11)	-10.0%	(106)	Expenditure Recovery	(1,187)	(1,319)	(132)	-10.0%	(639)
42	9,736	8,185	(1,551)	-18.9%	8,185	Operating Transfer Out	97,625	98,225	600	0.6%	68,730
43	427	427	0	n/a	187	Intrafund Transfer	5,129	5,129	0	n/a	2,248
44	0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0
45	551	635	84	13.2%	(160)	Continuing Projects	6,618	7,618	1,000	13.1%	5,047
46	<u>41,770</u>	<u>39,686</u>	<u>(2,084)</u>	<u>-5.3%</u>	<u>35,497</u>	TOTAL OPERATING EXPENSES	<u>482,707</u>	<u>476,246</u>	<u>(6,461)</u>	<u>-1.4%</u>	<u>414,947</u>
47											
48	<u>(13,275)</u>	<u>(15,097)</u>	<u>1,822</u>	<u>12.1%</u>	<u>(11,855)</u>	OPERATING INCOME/(LOSS)	<u>(176,961)</u>	<u>(184,386)</u>	<u>7,425</u>	<u>4.0%</u>	<u>(145,317)</u>
49											
NON-OPERATING REVENUE:											
51	8,020	8,020	0	n/a	6,757	General Fund	96,245	96,245	0	n/a	79,135
52	5,093	5,093	0	n/a	5,093	Realignment	61,113	61,113	0	n/a	61,113
53	285	285	0	n/a	317	Prop 99	3,423	3,423	0	n/a	3,102
54	487	487	0	n/a	212	Transfer In and Project-Related	5,846	5,846	0	n/a	3,728
55	1,207	1,207	0	n/a	250	Carryforward	14,482	14,482	0	n/a	(576)
56	73	73	0	n/a	79	Cafeteria	877	877	0	n/a	758
57	200	200	0	n/a	246	Miscellaneous	2,400	2,400	0	n/a	2,610
58	<u>15,365</u>	<u>15,365</u>	<u>0</u>	<u>n/a</u>	<u>12,954</u>	TOTAL NON-OPERATING REVENUE	<u>184,386</u>	<u>184,386</u>	<u>0</u>	<u>n/a</u>	<u>149,870</u>
59											
60	<u>2,090</u>	<u>268</u>	<u>1,822</u>	<u>679.9%</u>	<u>1,099</u>	NET INCOME/(LOSS)	<u>7,425</u>	<u>0</u>	<u>7,425</u>	<u>n/a</u>	<u>4,553</u>

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/2002
 Month Ending: MAR 31, 2002

CURRENT MONTH				
Actual	Budget	Variance	% Var	Prior Year
0	1,465	(1,465)	-100.0%	1,538
0	2,049	(2,049)	-100.0%	2,198
195	182	13	6.9%	183
88	92	(4)	-4.5%	90
28	21	7	31.9%	26
310	295	15	5.1%	299
140	140	0	0.3%	139
451	435	16	3.6%	438
7	7	0	n/a	8
0.0	6.4	6.4	100.0%	6.1
1,278	1,295	(0,017)	-1.3%	1,296
52.2%	48.5%	3.7%	7.5%	43.0%
18.3%	17.5%	0.8%	4.7%	18.1%
29.5%	34.0%	-4.5%	-13.2%	38.9%
100.0%	100.0%	0.0%	n/a	100.0%
6,319	4,793	1,526	31.8%	5,211
2,143	2,066	77	3.7%	1,936
1,152	2,286	(1,134)	-49.6%	2,121
9,614	9,145	469	5.1%	9,268
6,783	5,361	1,422	26.5%	5,221
2,143	2,102	41	2.0%	1,936
5,040	6,022	(982)	-16.3%	6,413
13,966	13,485	481	3.6%	13,570
19,622	18,859	763	4.0%	19,397
83.9%	81.0%	2.9%	3.6%	81.6%
2,483.6	2,380.0	(103.6)	-4.4%	2,347.1
218.3	329.0	110.7	33.6%	218.5
2,701.9	2,709.0	7.1	0.3%	2,565.6
334	334	0	n/a	334
3,036	3,043	7	0.2%	2,900
4.8	5.0	0.2	4.0%	4.6
\$ 63,250	\$ 60,126	(\$ 3,124)	-5.2%	\$ 60,147
24.0%	23.9%	-0.1%	-0.4%	18.5%
\$ 1,452	\$ 1,302	\$ 150	11.5%	\$ 1,255
\$ 763	\$ 643	\$ 120	18.7%	\$ 607
#DIV/0!	\$ 11,986	#DIV/0!	#DIV/0!	\$ 11,077
#DIV/0!	\$ 5,919	#DIV/0!	#DIV/0!	\$ 5,359
\$ 2,129	\$ 2,056	(\$ 73)	-3.6%	\$ 1,830
\$ 1,633	\$ 1,622	(\$ 11)	-0.7%	\$ 1,408
\$ -	\$ 18,927	\$ 18,927	100.0%	\$ 16,150
\$ -	\$ 14,932	\$ 14,932	100.0%	\$ 12,426
26.7%	32.5%	5.8%	17.8%	39.8%
82	80	(2)	-2.5%	107

KEY VOLUME INDICATORS

Discharges (incl. MHRF)
Discharges (incl. MHRF)
Adjusted Discharges (incl. MHRF)
Average Daily Census
Acute Med/Surg ADC
Psych ADC
Skilled Nursing ADC
Total ADC excl. MHRF
MHRF ADC
Total Adult ADC
Nursery ADC
Average Length of Stay (excl. MHRF)
Medicare Case Mix Index
Payor Mix (Gross Revenue)
Medi-Cal
Medicare
Other
Total
Patient Days
Medi-Cal Patient Days (excl. MHRF)
Medicare Patient Days (excl. MHRF)
Other Patient Days (excl. MHRF)
Total Patient Days(excl. MHRF)
Medi-Cal Patient Days
Medicare Patient Days
Other Patient Days
Total Patient Days
Adjusted Patient Days
% Occupancy (available beds)

KEY OPERATIONAL INDICATORS

Labor
FTEs - Productive
FTEs - Non-Productive
Total FTEs - SFGH Only
UC Non-Academic FTEs
Grand Total FTEs Incl. UC
FTEs Per AOB (incl. UC)
Average Labor Cost per SFGH FTE
Fringe Benefits as % of Salary
Revenues
Oper. Rev. Per Adjusted Patient Day (incl. MHRF)
Oper. Rev. (excl. SB855/1255/GME)/APD
Oper. Rev. Per Adjusted Discharge
Oper. Rev. (excl. SB855/1255/GME)/Adj. Discharge
Expenses
Operating Exp. Per Adjusted Pt. Day
Operating Exp.(excl. IGT)/Adj. Pt. Day
Operating Exp. Per Adj. Discharge
Operating Exp.(excl. IGT)/Adj.Discharge
Supply Expense as % of Net Pt. Revenue
Days Revenue in Accounts Receivable

YEAR-TO-DATE				
Actual	Budget	Variance	% Var	Prior Year
0	12,847	(12,847)	-100.0%	13,377
0	18,008	(18,008)	-100.0%	18,871
192	179	13	7.4%	191
92	92	(1)	-0.5%	92
27	20	7	34.0%	22
311	291	20	6.7%	305
139	140	(1)	-0.8%	136
450	431	19	4.3%	441
7	7	0	n/a	8
0.0	6.0	6.0	100.0%	6.3
1,278	1,295	(0,017)	-1.3%	1,296
46.5%	48.5%	-2.0%	-4.2%	44.3%
17.6%	17.5%	0.1%	0.5%	18.3%
36.0%	34.0%	2.0%	5.8%	37.4%
100.0%	100.0%	0.0%	0.0%	100.0%
49,639	41,852	7,787	18.6%	44,139
19,098	18,041	1,057	5.9%	19,051
16,356	19,964	(3,608)	-18.1%	20,608
85,093	79,857	5,236	6.6%	83,798
53,098	46,995	6,103	13.0%	49,219
19,098	18,425	673	3.7%	19,051
50,967	52,794	(1,827)	-3.5%	52,897
123,163	118,214	4,949	4.2%	121,167
171,372	165,716	5,656	3.4%	170,971
83.7%	80.3%	3.4%	4.2%	82.1%
2,378.1	2,380.0	1.9	0.1%	2,262.8
319.7	329.0	9.3	2.8%	339.5
2,697.8	2,709.0	11.2	0.4%	2,602.3
334	334	0	n/a	334
3,032	3,043	11	0.4%	2,936
4.8	5.0	0.2	3.1%	4.7
\$ 62,599	\$ 60,126	(\$ 2,473)	-4.1%	\$ 59,114
24.0%	24.0%	0.0%	n/a	23.3%
#REF!	#REF!	#REF!	#REF!	\$ 1,301
#REF!	#REF!	#REF!	#REF!	\$ 639
#REF!	#REF!	#REF!	#REF!	\$ 11,786
\$ -	#REF!	#REF!	#REF!	\$ 5,792
\$ 2,103	\$ 2,085	(\$ 18)	-0.9%	\$ 1,972
\$ 1,675	\$ 1,640	(\$ 35)	-2.1%	\$ 1,542
#DIV/0!	\$ 19,185	#DIV/0!	#DIV/0!	\$ 17,871
#DIV/0!	\$ 15,094	#DIV/0!	#DIV/0!	\$ 13,967
30.7%	32.7%	2.0%	6.1%	36.0%
82	80	(2)	-2.5%	107

Organizational Effectiveness Assessment Report

FY '01 - '02

April 9, 2002

Executive Summary

Background

In planning for the upcoming year, the leadership for SFGHMC embarked on a self-assessment of the Executive Committee, Nursing Executive Committee (NEC), Medical Executive Committee (MEC), and the Governing Body. These surveys were designed to evaluate quality of service and elicit recommendations to the Executive Committees.

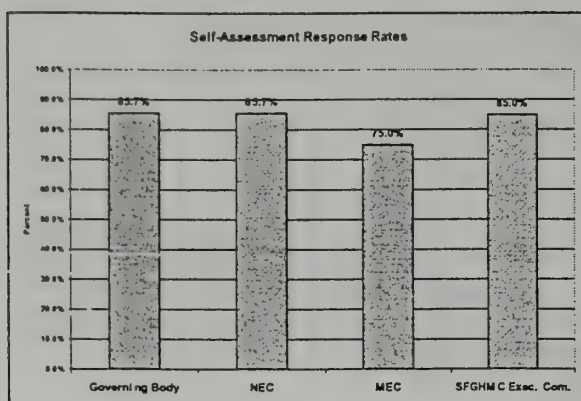
Methodology

The SFGHMC Executive Committee, Nursing Executive Committee, Medical Executive Committee and the Governing Body each designed their own self-assessment tool to be distributed to all members of their respective committees. These tools have been attached as appendices A, B, C, and D. Respondents were asked to rank the quality of each service on a scale (from one to three or one to five, depending on the survey) from "Needs Improvement" to "Excellent." In addition to these rankings, respondents also had the opportunity to write-in their own comments. Completing the self-assessment tool was optional and committee members had the option of submitting their forms anonymously. Members were given from a week to a month to complete and turn in their self-assessment.

Analysis

Data collected by the self-assessment tool were aggregated, with the exception of open-ended questions which were compiled without identifying the authors. The SFGHMC Executive Committee, the Nursing Executive Committee, and the Governing Body each employed a scale of 1 through 5 (1 = Excellent, 2 = Very Good, 3 = Good, 4 = Fair, 5 = Needs Improvement). Areas of Excellent/Good quality of service are identified by a median response greater than or equal to three. A service rated with a median of less than three is identified as an opportunity for improvement. The Medical Executive Committee used a scale of 1 through 3 (1 = Excellent, 2 = Good, 3 = Needs Improvement). Areas of Excellent/Good quality of service are identified by a median response greater than or equal to two. A service rated with a median of less than two is identified as an opportunity for improvement.

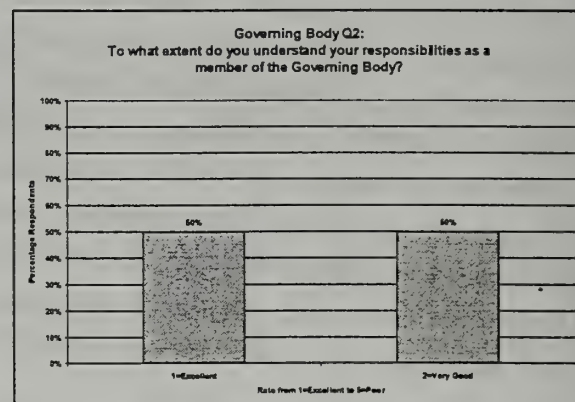
Summary of Results



members leading to a response rate of approximately 75 percent.

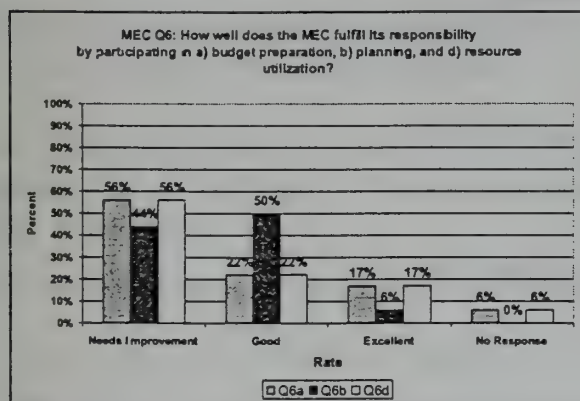
Structure/Responsibilities of the Committee.

The self-assessment tools demonstrated that members of the Executive Committees (Administrative, Medical and Nursing) and Governing Body have an Excellent or Good understanding of their responsibilities as a Member of their respective Executive Committee. The structure of these committees received similarly positive ratings. By use of the open ended Comment section, members of each group commended their Executive Committee's/ Governing Body's significant improvements: "the MEC has improved considerably;" "the (SFGHMC) Executive Committee is functioning at a much higher level than (before);" "The Governing Body is intimately involved with all aspects of SFGH and its policies." The chart above details the Governing Body's high ratings of member's understanding of their responsibilities.



Communication. It was recognized by the NEC (92 percent) and the MEC (89 percent) that communication between their respective Committee and the Executive Administrator was "Excellent" or "Good." The Governing Body also marked high scores for their communication to Medical Staff, and the CEO and SFGH Executive Administrator. However, the Governing Body, Medical Executive Committee and SFGHMC Executive Committees both expressed concern about how organization-wide issues are communicated from leadership to staff and from the Governing Body to the public. This is an issue to be addressed going forward.

Financial Management/Resource Allocation. While the 67 percent (eight of 12) of the Nursing Executive Committee rated their effectiveness at allocating resources Very Good or Excellent, 56 percent (10 of 18) of the Medical Executive Committee respondents indicated that their resource utilization needed improvement. Further, the Medical Executive Committee members included budget preparation and planning as additional areas below standard (see chart below). The NEC's ability to contribute to the development of an annual operating budget and long-term capital expenditure plan yielded the lowest marks on its self-assessment; their rating, however, was still



an admirable "Good." Similarly, the Governing Body registered "Good" for their success in performing its duties and responsibilities in providing for necessary resources, yet this and other questions surrounding improving financial viability, providing resources for quality management and risk management, and hospital advocacy received the lowest marks on the self-assessment. A member from the SFGHMC

Executive Committee recognized that managers and Administrative Associates needed support tools for managing their finances. Budget issues and financial management is an area that requires further attention of the Hospital's Leadership. Committee members mentioned the dangers of getting buried by administrative tasks and budget disagreements, leaving other important issues unresolved.

Conclusion

Overall, each of the surveys identified the need to further focus on the areas of: 1) Communication from leadership to staff; and 2) Financial Management/Resource Allocation particularly focused on communicating and further involving staff in budget issues and preparation. San Francisco General Hospital Medical Center (SFGHMC) Executive Committee, as the leadership for the hospital, will be focusing on these issues during their June 2002 retreat in preparation for strategizing for the coming fiscal year 2002-2003.

Table of Contents: Attachments

- A: Governing Body Self-Assessment Tool
- B: SFGHMC Executive Committee Self-Assessment Tool
- C: Medical Executive Committee Self-Assessment Tool
- D: Nursing Executive Committee Self-Assessment Tool

Annual Evaluation of the Health Commission as the Governing Body of San Francisco General Hospital Medical Center

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

	1	2	3	4	5
1) To what extent do you feel you understand the basic components of the Governing Body bylaws?					
2) To what extent do you understand your responsibilities as a member of the Governing Body?					
3) To what extent do you feel the Governing Body has been successful in performing its duties and responsibilities in the following:					
a) Establishing and continuously evaluating the mission of the hospital					
b) Setting goals and objectives (i.e. Planning)					
c) Developing, reviewing, and revising policies and procedures in a collaborative manner					
d) Promote Performance Improvement					
e) Provide for organizational management					
f) Provide for necessary resources					
g) Establishing a criteria-based process for selection of a qualified and competent CEO (Director of Health)					
h) Assessing and improving the quality of service					
i) Granting medical staff membership and/or privileges to applicants (appoint/reappointment changes)					
j) Assessing and strengthening the financial viability					
k) Providing for resources and support systems for the quality assessment and risk management functions					
l) Advocating for the hospital					
m) Complying with legal requirements					
n) Receive education about the performance improvement process					

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

	1	2	3	4	5
4) To what extent do you feel the Governing Body has provided for appropriate medical staff participation?					
5) To what extent do you feel the Governing Body has been effective in improving the quality of care and service throughout the hospital?					
6) To what extent do you feel the Governing Body has been successful in assuring the competency of the following:					
a) Medical staff members' performance					
b) Employees' performance					
c) Contract services' performance					
d) CEO's performance					
7) To what extent do you feel communication between the following has been effective:					
a) Governing Body and Medical Staff					
b) Governing Body and employees					
c) Governing Body, CEO, and SFGH Executive Administrator					
d) Governing Body and general public					
8) To what extent do you believe that there is adequate membership of the following on the Governing Body:					
a) Professional expertise, including health and business					
b) Diversity of the City/County population					
c) Community leaders					
9) To what extent do you believe the Governing Body has addressed "high priority" issues of the hospital over the past year?					
10) To what extent do you believe the Governing Body has been effective in conflict resolution?					
11) Do the minutes of the Governing Body have sufficient discussion of findings, conclusions, recommendations and actions taken?					

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

- 12) To what extent is quality assessment and improvement reported to the Governing Body?
- a) How well is performance improvement discussed in the Joint Conference Committee of SFGH, as communicated through the Joint Conference Committee minutes to the full Governing Body?
 - b) Does each member of the Governing Body have an opportunity to submit concerns on performance improvement?
 - c) Hospital-wide performance improvement activities reviewed regularly.
 - d) Performance improvement plans of departments/services are reviewed regularly.
 - e) Quality assessment and improvement plans of ancillary departments/services are reviewed regularly
 - f) Summaries of hospital-wide and medical staff monitoring and evaluating activities are reported on a regular basis
 - g) Regulatory agency and accrediting agency reports are shared with the Governing Body

[illegible]

13) To what extent do you feel the Governing Body has been adequately involved in policy-setting and oversight of the hospital?

Comments:

Self-Assessment of the Leadership (Executive Committee) of San Francisco General Hospital Medical Center

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

		1	2	3	4	5
1)	To what extent do you understand your responsibilities as a member of the Leadership?					
2)	To what extent do you feel Executive Committee has been effective in planning and designing services by:					
	a) Assessing patients' needs					
	b) Assessing public's and community's needs					
	c) Developing a mission					
	d) Prioritizing internal and external demands					
	e) Developing Vision					
	f) Assessing and strengthening the financial viability					
	g) Complying with legal requirements					
	h) Develop an annual operating budget and long-term capital expenditure plan					
3)	To what extent do you feel Executive Committee has been effective in directing services through the following:					
	a) communicating mission and vision to all staff					
	b) developing a strategic plan					
	c) developing a quality plan					
	d) establishing strategic goals for the fiscal year					
	e) establishing performance improvement priorities for the fiscal year					
4)	To what extent do you feel Executive Committee has been effective in integrating and coordinating services through the following:					
	a) Implementing goals for the year					
	b) Allocating resources to important functions					
	c) Aligning services and staff to important functions					
	d) Organizing and directing staff based on scope of services					
	e) Integrating services					

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

	1	2	3	4	5
5) To what extent do you feel Executive Committee has been effective in improving organizational performance through the following:					
a) Assessing alignment of activities with mission					
b) Continuing progress					
c) Adjusting priorities in response to urgent or unusual events					
6) To what extent do you feel the Executive Committee has been successful in assuring the competency of the following:					
a) Employees' performance					
b) Contract services' performance					
7) To what extent do you feel the Executive Committee has been successful in providing for "one standard of care?"					
8) To what extent do you feel communication between the following has been effective:					
a) Executive Staff and Medical Staff					
b) Executive Staff and employees					
c) Executive Staff and Executive Administrator					
d) Executive Staff and Governing Body					
9) To what extent do you believe the Executive Staff has addressed "high priority" issues of the hospital over the past year?					
10) To what extent are the final solutions to issues appropriate?					

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

11) To what extent is performance improvement reported to the Executive Staff?

a) How well are quality improvement issues communicated to the Executive Committee from Medical and Nursing Executive Committees?

b) Summaries of hospital-wide and medical staff monitoring and evaluation activities are reported on a regular basis.

c) Regulatory agency and accrediting agency reports are shared with the Executive Committee

12) To what extent do you feel the Executive Committee has been adequately involved in the policy-setting and oversight of the management of the hospital?

1	2	3	4	5

Comments:

SFGHMC Medical Executive Committee Self-Assessment Tool 2002

March 7, 2002

To: Members of the Medical Executive Committee

From: J. Renee Navarro, PharmD, MD, Chief of Staff, SFGHMC

In an effort to better direct the work of both the Administrative and Clinical Medical Executive Committees I am conducting the following assessment. Please complete and forward to me. Rank the following items from:

Key: 3) Excellent 2) Good 1) Needs improvement

	3	2	1
1. To what extent do you understand your responsibilities as a Member of the MEC?			
2. Does the MEC consist of a sufficient number of members to function effectively and efficiently?			
3. To what extent has the MEC encouraged members to identify areas that need further development or additional information?			
4. How well do the Bylaws (and accompanied manuals):			
a) Identify the role and responsibilities of the medical staff?			
b) Provide guidance that MEC members need to carry out their Responsibilities?			
c) Provide sufficient flexibility to the MEC in carrying out its responsibilities?			
5. Relative to the MEC meetings. They are:			
a) Scheduled at appropriate intervals?			
b) Well advertised and preceded by agenda and related items?			
c) Well organized and followed by the agenda?			
6. How well does the MEC fulfill its responsibility by participating in:			
a) Budget Preparation?			
b) Planning?			
c) Accreditation Activities?			
d) Resource Utilization?			
7. How well does the MEC effectively communicate Hospital, Governance and medical staff issues to the Medical Staff as a Whole?			
8. How well does the MEC over see the activities of Medical Staff Committees?			

SFGHMC Medical Executive Committee Self-Assessment Tool 2002

Key: 3) Excellent 2) Good 1) Needs improvement

3 2 1

9. How well does the Hospital Administration (CEO) communicate and participate in the MEC?			
10. How well does Administration respond to issues of the MEC?			
11. To what extent is performance improvement information reported to the MEC?			
12. To what extent do you feel that MEC, as the leadership for the Medical Staff, continuously assesses and promotes performance improvement?			
13. How well is the MEC informed about regulatory requirements?			

Name three MEC priorities for the next twelve months:

1)

2)

3)

ADDITIONAL COMMENTS:

T:\COMMITTEES - MED STAFF\Medical Exec Comm - ADMIN2002 MEC - ADMIN2002 MEC Self Assessment Tool.doc

Self-Assessment of the Nursing Leadership of San Francisco General Hospital Medical Center

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

	1	2	3	4	5				
1) To what extent do you understand your responsibilities as a member of Nursing Leadership?									
2) To what extent do you feel the Nursing Executive Committee has been effective in planning and designing services by:									
a) Assessing patients' needs									
b) Assessing and strengthening the financial viability of the Hospital									
c) Complying with legal requirements									
d) Contributing to the development of an annual operating budget and long-term capital expenditure plan									
3) To what extent do you feel the Nursing Executive Committee has been effective in directing Nursing Services through the following:									
a) communicating mission and vision to all staff									
b) developing a performance improvement plan									
c) establishing goals for the fiscal year based on the Hospital's strategic									
d) establishing performance improvement priorities for the fiscal year									
4) To what extent do you feel the Nursing Executive Committee has been effective in integrating and coordinating services through the following:									
a) Implementing goals for the year									
b) Allocating resources to important functions									
c) Aligning services and staff to important functions									
d) Organizing and directing staff based on scope of services									
e) Integrating services									

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

	1	2	3	4	5
5) To what extent do you feel the Nursing Executive Committee has been effective in improving organizational performance through the following:					
a) Continuing progress					
b) Adjusting priorities in response to urgent or unusual events					
6) To what extent do you feel the Nursing Executive Committee has been successful in assuring the competency of the following:					
a) Employees' performance					
b) Contract services' performance					
7) To what extent do you feel the Nursing Executive Committee has been successful in providing for "one standard of care?"					
8) To what extent do you feel communication between the following has been effective:					
a) Nursing Executive Staff and Medical Staff					
b) Nursing Executive Staff and employees					
c) Nursing Executive Staff and Executive Administrator					
d) Nursing Executive Staff and Governing Body/JCC					
9) To what extent do you believe the Nursing Executive Staff has addressed "high priority" issues of the hospital over the past year?					

Key: 1= Excellent 2= Very Good 3= Good 4= Fair 5= Needs Improvement

11) To what extent is performance improvement reported to the Nursing Executive Staff?

a) How well are quality improvement issues communicated to the Nursing Executive Committee from Nursing Quality Improvement Committee?

b) Summaries of hospital-wide monitoring and evaluation activities are reported.

c) Regulatory agency and accrediting agency reports are shared with the Nursing Executive Committee.

12) To what extent do you feel the Nursing Executive Committee has been adequately involved in the policy-setting and oversight of the management of Nursing Services?

1	2	3	4	5

Comments:

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

20.458
4/02
Edward A. Chow, M.D.
President

Roma P. Guy, M.S.W.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

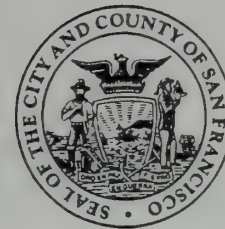
Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor
Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

Tel. (415) 554-2666
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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, May 14, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

MAY 9 2002

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF APRIL 9, 2002
**Minutes of April 9, 2002*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGHMC)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Officer)
**Report*
- 5) FOR DISCUSSION: FINANCE REPORT - STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
**Report*

6) PUBLIC COMMENT**

7) CLOSED SESSION

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: APPROVAL OF CLOSED SESSION MINUTES
OF APRIL 9, 2002

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT,
QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: CONSIDERATION OF CREDENTIALING MATTERS
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION
AND POSSIBLE
ACTION: MEDICAL STAFF REPORT
J. Renee Navarro, M.D., Chief of Staff

D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

8) ADJOURNMENT

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

* Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at:

www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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102
Edward A. Chow, M.D.
President

Roma P. Guy, M.S.W.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

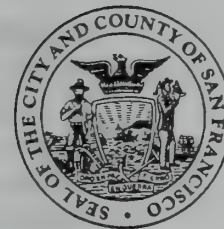
David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, May 14, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

JUN 7 2002

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1) CALL TO ORDER

The San Francisco General Hospital Joint Conference Committee meeting was called to order by Commissioner Lee Ann Monfredini at 3:45 p.m.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D. – arrived at 4:20 p.m.

Staff: Wahid Choudhury, Sue Currin, Myra Garcia, Mozettia Henley, John Luce, M.D., Beth Maloney, Kathleen Murphy, Renee Navarro, M.D., Gene O'Connell, Gregg Sass, Cathryn Thurow, Hiroshi Tokubo, Connie Young.

2) APPROVAL OF MINUTES OF APRIL 9, 2002

Action Taken: The committee approved the minutes of the April 9, 2002 San Francisco General Hospital Joint Conference Committee.

3) HOSPITAL HEALTHCARE UPDATE

Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center, presented the Hospital Healthcare Update.

Program Updates

JCAHO Preliminary Results and Next Steps

As reported at last week's Health Commission meeting, San Francisco General Hospital Medical Center has successfully completed their Consolidated Accreditation and Licensure Survey (CALs). This year's survey was conducted from April 22nd to April 26th and involved over 16 surveyors from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Institute for Medical Quality (IMQ) and the State Department of Health Services (DHS).

As part of the survey, all areas licensed under SFGHMC were surveyed, including all of the acute services, emergency services, diagnostic services, the Mental Health Rehabilitation Facility, the Hospital-based Primary Care and Specialty Clinics, and Bridge to Wellness. The hospital, Mental Health Rehabilitation Facility (MHRF), and Bridge to Wellness were surveyed and accredited under three different JCAHO manuals. The hospital was surveyed under the Hospital Manual and received a successful preliminary score of 84%. The MHRF was surveyed under the Long Term Care Manual and received a preliminary score of 97%. Bridge to Wellness was surveyed under the Behavioral Manual and received a perfect preliminary score of 100%.

Although San Francisco General Hospital Medical Center has not yet received the official final scores from JCAHO, the Leadership has already begun developing follow-up action plans to both the preliminary Type I and Supplemental findings, assigning a Leadership member as the "expert" person to develop the action plan with support and constant communication with Quality Management. After a comprehensive debriefing, the Executive Committee has agreed that it will pursue the appealment of certain Type I's and will work on gathering data to support the appeal while waiting for receipt of the official report.

In addition to addressing the JCAHO official findings, the Leadership will be engaging in internal assessments of how to better prepare for JCAHO surveys through gathering feedback from managers and line staff in determining successful mechanisms/processes to maintain JCAHO "readiness." The various internal assessments will occur throughout this summer and will be collated and analyzed by the Executive Committee.

SFGH staff thanks President Edward Chow, Commissioner Lee Ann Monfredini and Commission John Umekubo for their support and participation prior and during the survey. SFGH will continue to report to the JCC-SFGH is ongoing progress related to JCAHO findings and maintaining JCAHO readiness.

Avon Products Foundation Comprehensive Breast Center

As required by Section 10.110 of the San Francisco Administrative Code and consistent with the Health Commission policy on gifts, the gift of construction of the comprehensive breast cancer and associated equipment from the Avon Products Inc. to San Francisco General Hospital will be brought forward for consideration and approval at the May 21st Health Commission Budget Committee.

Avon Products Inc. will grant \$3,600,000 to the San Francisco General Hospital Foundation (SFGH Foundation) for the construction and equipment costs associated with the building of a comprehensive breast center at SFGH. It should be noted that the City and County of San Francisco and the Department of Public Health will not receive any funds from the gift. Instead, the funds will be granted to the SFGH Foundation, which will manage the construction of the center and the purchase of its equipment. Upon completion (estimated to be May 2003), the SFGH Foundation

will grant the building and equipment to San Francisco General Hospital. Prior to its actual construction, the Department of Public Health is seeking approval from the Health Commission and the Board of Supervisors to accept the gift of the building funded by the Avon Products Inc., through the San Francisco General Foundation.

As a condition of the granting of funds, Avon Products has required that the breast center be named the "Avon Products Foundation Comprehensive Breast Center", for a minimum of 20 years. Once approved, the Department will begin using its official name.

Services Performed

Currently, there is no central treatment facility at SFGH to provide breast exams and cancer treatment. At this time, breast cancer treatment services are provided at various locations within San Francisco General Hospital, including the radiology department, the 3M primary care clinic, Ward 86 primary care clinic, and the Operating Room. The new 4,000 square foot building will enable SFGH to consolidate and coordinate breast cancer screening and treatment within one location, and will expand the capacity for providing these services.

The services within the new breast center will focus primarily on decreasing exam wait times (currently 142 days for routine exams, and 39 days for diagnostic exams) and increasing the number of screening mammograms performed each year. Currently, SFGH performs 5,000 annual mammograms. With the new facility, SFGH will have the capacity to perform 10,000 mammograms each year, which is consistent with the current demand for this diagnostic procedure.

In addition to increasing the capacity of mammography at the breast center, new services will also be delivered, including stereotatic core biopsies, and vacuum assisted large core ultrasound breast biopsies. These increased services will be provided by existing staff and new radiology staff approved in the current budget who are currently providing breast screening and treatment services at SFGH.

The gift of \$3.6 million will fund construction, site preparation, mammography units, ultrasound equipment, and video equipment. The funds will be accepted and expended by the SFGH Foundation, which will manage and oversee the project. All design work, final construction, and equipment purchases will be made pursuant to approval of the San Francisco General Hospital Chief Executive Officer and her staff.

Impact of Pending Upper Payment Limit (UPL) Legislation

There is currently pending State and Federal policies which, if all enacted, could result in a loss of \$539 million to California's safety net hospitals, including a loss of \$18.1 million to San Francisco General Hospital (SFGH), if passed and enacted. The legislation propose reducing the Upper Payment Limit (UPL) from 150% to 100%, reducing the Disproportionate Share Hospital (DSH) program and increasing the State DSH Administrative Fee. This is described in further detail below:

Medicaid Upper Payment Limit (UPL)

Issue

The current upper payment limit (UPL) for non-State public hospitals requires that states receive no more Medicaid services than 150 percent of what Medicare would pay for comparable services. On November 23, 2001, the Bush Administration issued regulations that reduced the UPL for these hospitals from 150 percent to 100 percent.

Medicaid supplemental payments are critical to San Francisco's safety net health system and a reduction of this magnitude would reduce services to our community's low-income, uninsured and Medicaid populations.

Background

A carefully crafted bipartisan compromise regarding the use of federal Medicaid funds under the UPL was achieved in late 2000 as part of the Benefits Improvement and Protection Act and became effective in March 2001. The compromise regulation provided a higher UPL for public hospitals – 150 percent instead of 100 percent – in recognition of their higher costs for treating vulnerable populations and their significant role as safety-net providers.

Unfortunately, several states – *not* California – are using supplemental Medicaid payments for non-health care expenditures. The new rule was issued to close the “loophole” that allows states to do this. However, the rule will also apply to states like California, where all federal Medicaid funds are used exclusively to provide healthcare services to low-income and medically needy patients. Over the years, these funds have become an integral part of the patchwork of funding that supports safety net hospitals. The loss of these funds will push California's fragile and unstable financing system to the brink of collapse. A 100 percent UPL will result in *annual losses of \$300 million to public hospitals in California, including a loss of at least \$10 million to San Francisco General Hospital*. A reduction of this magnitude would threaten the financial stability of SFGH and our ability to continue to provide the high quality health care services our community needs.

Request

The Department of Public Health seeks preservation of the 150 percent UPL for California. Neither a one-year fix nor a transition plan that phases out the program will provide sufficient protection for San Francisco and will severely harm the State's safety net health care system. A permanent response is necessary for San Francisco to continue to meet the health care needs of our most vulnerable and medically fragile populations.

Federal DSH Cliff

Steep federal reductions to the Medicaid Disproportionate Share Hospital (DSH) program are scheduled to begin in October 2002. This is called the DSH Cliff. Without legislative intervention, the DSH Cliff will result in losses of \$184 million to California's safety net hospitals and \$6.2 million to SFGH.

State DSH Administrative Fee

In order to help the State balance its budget, the Governor seeks to increase by \$55 million the “administrative fee” in the DSH program. This would nearly triple the State's current administrative fee, bringing the total to \$84.8 million. If this proposal is enacted, SFGH would lose \$1.9 million in DSH funding beginning in July 2002.

The Impact of DSH on San Francisco General Hospital

If SFGH were required to sustain an \$8.1 million loss, it would have to reduce critical hospital services. Following is an example of how the proposed funding reductions would impact SFGH:

- **22 acute care beds for the physically and mentally ill would be eliminated.** This would reduce the hospital's capacity to provide inpatient care by 8,000 days and leave 1,600 patients without access to acute care services at SFGH each year.

- **One outpatient clinic would be eliminated.** This would reduce the hospital's outpatient capacity by 26,000 visits, representing services to 4,800 patients each year. A reduction of this magnitude would leave patients with reduced access to regular medical care and would result in increased utilization of SFGH's already taxed emergency department.
- **The existing ambulance diversion rate of 25 percent would double and ambulances would be rerouted from SFGH to other San Francisco hospitals 50 percent of the time.** Because SFGH receives 14,000 ambulances each year – more than twice as many as every other hospital in San Francisco – a drastic increase in the diversion rate would affect not only SFGH, but the entire system of emergency care in San Francisco.
- **The hospital's Level I trauma center status would be jeopardized.** In order to meet the standards of a Level I trauma center, SFGH must always be at the ready with specialized equipment and a panel of physician specialists and staff in the emergency department, intensive care, operating rooms and radiology who are immediately available, 24 hours a day, 7 days a week, to handle the most challenging traumatic injuries. With a loss of \$8.1 million the hospital's ability to fund physician services, such as neurosurgeons, orthopedic surgeons, general surgeons and radiologists, would be compromised and SFGH would have difficulty maintaining the level of readiness required for a Level I trauma center.
- **The hospital's ability to maintain and upgrade critical health care equipment would be severely compromised.**

The Solutions: Federal and State

Federal DSH Cliff

Congress may prevent the DSH Cliff by passing H.R. 854 and S. 572, the "Medicaid Safety Net Hospital Continued Preservation Act." This important legislation, which safeguards essential funding to states to support access to care for low-income individuals through the Medicaid program, has strong bipartisan support, with a majority of the California congressional delegation – and all of San Francisco's delegation – signed on as co-sponsors.

State DSH Administrative Fee

The Department of Public Health strongly believes that California should protect the health care safety net and eliminate the Medi-Cal DSH administrative fee. Given the current budget deficit, it is recognized that complete elimination of the DSH administrative fee may not be feasible at this time. However, at a minimum, the fee should be held at its current level of \$29.8 million in the state's 2002-03 budget.

We continue to support the Department's stance and recently participated in a Press Event at the hospital sponsored by Health Access focused on the impact of the Federal DSH Cliff and State DSH Administrative Fee proposed legislation. We will continue to inform the JCC-SFGH any movement connected to proposed UPL legislation.

Commissioners' Comments

- Commissioner Monfredini asked what timeframe the hospital has to rectify the Type I findings. Ms. O'Connell said that they have six months to submit a written report that says how the hospital is meeting the standard.

4) **PATIENT CARE REPORT**

Sue Currin, RN, Chief Nursing Officer, presented the Patient Care Report (Attachment A). Ms. Currin said the union has written several letters asking the City to reopen the nursing contract. In addition, the City's budget analyst is doing an audit of the hospital. The focus for the next 30 days is to gather data pertinent to the budget process. The budget analyst is focusing on the biggest budget areas, including nursing services. With regard to diversion, there was an 11% increase over last month. The census has been very high and Ms. O'Connell said that the people who are coming to the emergency room are very sick. Most of the incidents were due to overcrowding rather than the hospital's lack of capacity for inpatients.

5) **FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES**

Gregg Sass, CHN Chief Financial Officer, presented the Finance Report (Attachment B). Mr. Sass noted that in April there was an extremely high positive variance in Gross Patient Revenue and a significant negative variance in expenses. He is still projecting an \$8.5 million year-end surplus. Mr. Sass said that the investment in accounts receivable are 81 days for April, which represents an all-time low for the hospital.

6) **PUBLIC COMMENT**

None.

7) **CLOSED SESSION**

A) **Public Comments on All Matters Pertaining to the Closed Session**

None.

B) **Vote on Whether to Hold a Closed Session**

Action Taken: The Committee voted to hold a closed session.

The Committee went into closed session at 4:15 p.m. Present in closed session were the same people that were present in open session with the exception of Gregg Sass and Wahid Choudhury. (Commissioner Umekubo arrived at 4:20 p.m.).

C) **Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1**

APPROVAL OF CLOSED SESSION MINUTES OF APRIL 9, 2002

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

CONSIDERATION OF CREDENTIALING MATTERS

J. Renee Navarro, M.D., Chief of Staff

Action Taken: The Committee approved the Credentials Report.

MEDICAL STAFF REPORT

J. Renee Navarro, M.D., Chief of Staff

D) **Reconvene in Open Session**


The Committee reconvened in open session at 4:26 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose discussions held in closed session.

8) **ADJOURNMENT**

The meeting was adjourned at 4:27 p.m.



Michele M. Olson
Executive Secretary to the Health Commission

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 5/14/02

Sue Currin, RN, MS, Chief Nursing Office

1. Nursing Research Conference

San Francisco General Hospital was one of six hospitals that sponsored the Research & Quality in Action conference on May 2, 2002. The focus of the conference was to recognize, disseminate and celebrate research and quality patient care studies. We were proud to have Paul Koo, RN, MS and Sheryl Calson, RN, MS selected as featured speakers on "The Treatment of Alcohol Withdrawal in a University Affiliated County Hospital." The two SFGH poster presentations accepted were Diane Vaccaro, RN, MS and Christine Martin, RN, MS for "Research Utilization for Product Evaluation and Outcome Measurements of Vacuum Assisted Wound Closure" and Gail Schlueck for "Three Key Performance Indicators in the Endoscopy Suite."

2. Recruitment & Retention Activities

The Nursing Leadership Council sponsored several Nurse Week activities at SFGH. Approximately 100 attended the program entitled Celebration of Nursing: Status of Nursing Across the Nation with Mary Foley, President-American Nurses Association, held on May 3, 2002. Nancy Pelosi, Member of Congress, sent a letter acknowledging the contributions of DPH nurses to the health of the community and a proclamation from Mayor Willie Brown was read.

Eighty nurses attended a film festival held on May 6, 2002 featuring "An American Nurse at War: The story of Red Cross Nurse Marian McCune Rice" and nursing promotion TV advertisements by Johnson & Johnson.

SFGH Nursing Services hosted a successful recognition and recruitment reception for nursing staff on May 7. Approximately 300 attendees, including invited nursing students, listened to Ruth Ann Terry from the California Board of Registered Nursing speak on current developments in the nursing profession. Nursing student attendees were enthusiastic about starting their nursing careers at SFGH and expressed interest in working at SFGH during their school breaks. The development of a student nurse assistant position is being explored with HR.

Additional projects under development are a Nurse Mentor program for new graduate nurses, a 20/20 scholarship program, a nursing training grant with the San Francisco Private Industry Council, and the development of the Dorothy Washington Nursing Scholarship Fund. A nursing satisfaction survey was distributed in mid April and is

currently being collated. Results will be distributed and discussed with nursing staff in June.

Recruitment efforts are currently focused on new graduates who will be ready for employment in early June. Training Programs are scheduled in Critical Care, ED, and Med-Surg for the early summer. We have been able to advertise on the homepages of local schools of nursing and have received an excellent response.

3. Diversion Summary Report

See attached.

San Francisco General Hospital

Diversion Report

April 2002

EXECUTIVE SUMMARY

The Emergency Department [ED] recorded 39 episodes of diversion for 294 hours representing a rate of 40.8% in **April 2002**. This is an 11% increase in diversion since **March 2002**.

The 39 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from Previous Month
Total diversion	39	294	40.8	11%
Trauma override	6	13	1.8	.1%

The ED was impacted by capacity and high patient acuity during the episodes of total diversion and trauma override. During this time, **268** patients were awaiting admission to in-patient beds [ICU-20, 4B/StepDown-79, 5E-1, MedSurg-168]. **In April 2001, the ED was on diversion 24% of the month. Trauma Override was invoked 3% of the month in March 2001.**

Total diversion was recorded for 39 episodes, a total of 294 hours or a 40.8% rate for April 2002. While on Total Diversion the ED held 268 patients.

Trauma override was recorded for 6 episodes, a total of 13 hours or a 1.8% rate for April 2002. This is a .1% increase in trauma override from March 2002. While on Trauma override the ED held 39 patients awaiting inpatient beds.

DEFINITIONS

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSS definitions:

Total diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

*Prepared by: Sharon Kennedy R.N.
Base Hospital Coordinator*

San Francisco General Hospital
Emergency Department
April 2002
Total Diversion Summary

In April 2002, the Emergency Department recorded 39 episodes of Total Diversion for 294 hours, a percentage of 40.8% for the month.

Date	Length	Summary of Event
04/01/02	0000-0235 (2h 35m)	25 patients in the ED Admits: 1-ICU; 1-4B; 5-Floor Fast Track: Closed ED waiting room: 5 urgent patients
04/01/02	1400-0400 (14h)	32 patients in the ED Admits: 11 Fast Track: Closed ED waiting room: 6 urgent patients
04/01/02	2300-0400 (5h)	43 patients in the ED Admits: 1-ICU; 4-4B; 9-Floor Fast Track: Open ED waiting room: 14 urgent patients
04/02/02	1520-2230 (7h 10m)	34 patients in the ED Admits: 4-Floor Fast Track: Closed ED waiting room: 4 urgent patients
04/03/02	0015-1025 (10h 10m)	54 patients in the ED Admits: 1-ICU; 2-4B; 13-Floor Fast Track: Open ED waiting rooms: 5 urgent patient
04/03/02	1145-2200 (10h 15m)	37 patients in the ED Admits: 16-Floor Fast Track: Open ED waiting room: 4 urgent patients
04/04/02	1052-0010 (13h 18m)	28 patients in the ED Admits: 2-ICU; 2-4B; 5-Floor Fast Track: Open ED waiting room: 2 urgent patients
04/05/02	1229-2155 (9h 26m)	36 patients in the ED Admits: 1-ICU; 2-4B; 7-Floor Fast Track: Open ED waiting room: 8 urgent patients
04/06/02	1500-2130 (6h 30m)	34 patients in the ED Admits: 1-ICU; 2-4B; 6-Floor Fast Track: Closed ED waiting room: 10 urgent patients
04/06/02	2311-0620 (7h 9m)	46 patients in the ED Admits: 1-ICU; 2-4B; 2-Floor Fast Track: Open ED waiting room: 16 urgent patients
04/07/02	1342-2041 (6h 59m)	37 patients in the ED Admits: 2-4B; 5-Floor Fast Track: Open ED waiting room: 7 urgent patients
04/08/02	0027-0437 (4h 10m)	40 patients in the ED Admits: 5-Floor Fast Track: Closed ED waiting room: 6 urgent patients

04/08/02	1253-0907 (20h 14m)	32 patients in the ED Admits: 1-ICU; 4-4B; 5-Floor Fast Track: Open ED waiting room: 8 urgent patients
04/09/02	1535-2040 (5h 5m)	35 patients in the ED Admits: 2-4B; 7-Floor Fast Track: Open ED waiting room: 9 urgent patients
04/10/02	1247-0159 (13h 12m)	34 patients in the ED Admits: 5-4B; 6-Floor Fast Track: Closed ED waiting room: 7 urgent patients
04/11/02	0016-0613 (5h 57m)	45 patients in the ED Admits: 7-4B; 1-Floor Fast Track: Open ED waiting room: 16 urgent patients
04/11/02	1120-1820 (7h)	38 patients in the ED Admits: 2-ICU; 1-4B; 1-5E; 5-Floor Fast Track: Open ED waiting room: 8 urgent patients
04/12/02	1315-0036 (11h 21m)	30 patients in the ED Admits: 2-ICU; 1-Floor Fast Track: Open ED waiting room: 8 urgent patients
04/13/02	0345-0715 (3h 30m)	44 patients in the ED Admits: 2-4B; 2-Floor Fast Track: Open ED waiting room: 1 urgent patient
04/13/02	1425-1750 (3h 25m)	37 patients in the ED Admits: 3-4B; 2-Floor Fast Track: Open ED waiting room: 1 urgent patient
04/14/02	1250-1720 (4h 30m)	38 patients in the ED Admits: 3-4B; 2-Floor Fast Track: Open ED waiting room: 4 urgent patients
04/15/02	1140-2150 (10h 10m)	31 patients in the ED Admits: 2-4B; 4-Floor Fast Track: Open ED waiting room: 9 urgent patients
04/16/02	1215-1655 (4h 40m)	44 patients in the ED Admits: 2-Floor Fast Track: Open ED waiting room: 6 urgent patients
04/16/02	2030-2130 (1h)	34 patients in the ED Admits: 1-4B; 3-Floor Fast Track: Open ED waiting room: 5 urgent patients
04/17/02	1253-1615 (3h 22m)	32 patients in the ED Admits: 2-4B; 5-Floor Fast Track: Open ED waiting room: 3 urgent patients
04/17/02	1740-2100 (3h 20m)	37 patients in the ED Admits: 1-ICU; 1-4B; 6-Floor Fast Track: Closed ED waiting room: 5 urgent patients
04/18/02	2100-0130 (4h 30m)	33 patients in the ED Admits: 1-ICU; 2-4B; 3-Floor Fast Track: Closed ED waiting room: 15 urgent patients
04/19/02	1334-2010 (6h 36m)	39 patients in the ED Admits: 3-4B Fast Track: Open ED waiting room: 5 urgent patients

04/21/02	1130-1235 (1h 5m)	28 patients in the ED Admits: 2-Floor Fast Track: Open ED waiting room: 4 urgent patients
04/21/02	1719-1822 (1h 3m)	42 patients in the ED Admits: 2-4B; 4-Floor Fast Track: Open ED waiting room: 7 urgent patients
04/21/02	2140-0238 (4h 58m)	37 patients in the ED Admits: 2-4B; 5-Floor Fast Track: Open ED waiting room: 8 urgent patients
04/22/02	1426-1/352 (23h 26m)	33 patients in the ED Admits: 3-4B; 1-Floor Fast Track: Open ED waiting room: 8 urgent patients
04/23/02	1920-0655 (11h 35m)	25 patients in the ED Admits: 2-4B; 2-Floor Fast Track: Open ED waiting room: 11 urgent patients
04/24/02	0130-0700 (5h 30m)	42 patients in the ED Admits: 5-4B; 2-Floor Fast Track: Open ED waiting room: 10 urgent patients
04/24/02	1117-1745 (6h 28m)	35 patients in the ED Admits: 1-ICU; 1-4B; 3-Floor Fast Track: Open ED waiting room: 5 urgent patients
04/25/02	1550-0142 (9h 52m)	36 patients in the ED Admits: 2-ICU; 2-4B; 3-Floor Fast Track: Open ED waiting room: 5 urgent patients
04/26/02	1355-1730 (3h 35m)	44 patients in the ED Admits: 7-Floor Fast Track: Open ED waiting room: 12 urgent patients
04/29/02	1850-0640 (11h 50m)	37 patients in the ED Admits: 2-ICU; 3-Floor Fast Track: Closed ED waiting room: 10 urgent patients
04/30/02	1635-0405 (10h 30m)	32 patients in the ED Admits: 3-4B; 3-Floor Fast Track: closed ED waiting room: 7

San Francisco General Hospital
Emergency Department
April 2002
Trauma Override Summary

The Emergency Department recorded 6 episodes of Trauma Override for
13 hours, a percentage of 1.8% for the month of April.

Date	Length	Summary of Event
04/06/02	2357-0325 (3h 52m)	911-1 912-1 910-0
04/15/02	1906-2106 (2h)	911-3 912-2 910-0
04/24/02	0010-0305 (2h 55m)	911-0 912-0 910-1
04/25/02	1845-2000 (1h 15m)	911-1 912-3 910-0
04/26/02	1545-1730 (1h 45m)	911-0 912-1 910-1
04/29/02	2311-0040 (1h 19m)	911-1 912-0 910-0

SAN FRANCISCO GENERAL HOSPITAL
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/2002

Month Ending: APR 30, 2002

(In Thousands of Dollars)

MONTHLY						ANNUAL					
Fav/(Unfav)						Fav/(Unfav)					
Projection	Budget	Variance	% Var.	PY Actual		Projection	Budget	Variance	% Var.	PY Actual	
GROSS PATIENT REVENUE:						GROSS PATIENT REVENUE:					
17,955	14,070	3,885	27.6%	11,954	Inpatient Medi-Cal Revenue	193,853	153,066	40,787	26.6%	153,288	
4,661	4,664	(3)	-0.1%	4,180	Outpatient Medi-Cal Revenue	50,768	50,488	280	0.6%	50,578	
6,650	4,934	1,716	34.8%	5,340	Inpatient Medicare Revenue	68,884	63,169	5,715	9.0%	63,264	
2,088	1,836	252	13.7%	1,945	Outpatient Medicare Revenue	23,874	23,382	492	2.1%	23,428	
7,056	8,478	(1,422)	-16.8%	11,219	Inpatient Other Revenue	111,815	117,428	(5,613)	-4.8%	117,606	
6,296	4,633	1,663	35.9%	5,273	Outpatient Other Revenue	72,567	63,876	8,691	13.6%	63,963	
44,706	38,615	6,091	15.8%	39,911	TOTAL PATIENT SERVICE REVENUE	521,761	471,409	50,352	10.7%	472,127	
REVENUE DEDUCTIONS:						REVENUE DEDUCTIONS:					
5,527	6,396	869	13.6%	10,865	Charity Care	62,326	80,100	17,774	22.2%	80,879	
11,003	14,354	3,351	23.3%	11,989	Provision for Medi-Cal Adjustments	184,580	154,844	(29,736)	-19.2%	151,423	
2,255	2,436	181	7.4%	3,447	Provision for Medicare Adjustments	46,163	42,946	(3,217)	-7.5%	41,734	
7,058	3,855	(3,203)	-83.1%	1,756	Provision for Other Adjustments	70,881	54,518	(16,363)	-30.0%	60,550	
1,875	2,007	132	6.6%	1,917	Provision for Bad Debt	22,500	22,200	(300)	-1.4%	19,021	
27,718	29,048	1,330	4.6%	29,974	TOTAL REVENUE DEDUCTIONS	386,450	354,608	(31,842)	-9.0%	353,607	
16,988	9,567	7,421	77.6%	9,937	NET PATIENT SERVICE REVENUE	135,311	116,801	18,510	15.8%	118,520	
OTHER OPERATING REVENUE:						OTHER OPERATING REVENUE:					
710	710	0	n/a	705	Capitation/Managed Care Settlement	8,519	8,519	0	n/a	10,124	
379	421	(42)	-10.0%	388	Short Doyle	4,554	5,054	(500)	-9.9%	4,654	
10,656	10,515	141	1.3%	10,626	SB855	127,867	126,183	1,684	1.3%	104,112	
1,642	1,808	(166)	-9.2%	1,833	SB1255	19,700	21,700	(2,000)	-9.2%	22,000	
108	108	0	n/a	108	GME	1,300	1,300	0	n/a	1,300	
594	660	(66)	-10.0%	830	Revenue from Other City Departments	7,132	7,924	(792)	-10.0%	9,391	
(700)	0	(700)	n/a	0	Prior Year Settlement	710	0	710	n/a	(4,556)	
333	365	(32)	-8.8%	333	MAA & Other Net Patient Revenue	4,000	4,381	(381)	-8.7%	4,085	
13,722	14,587	(865)	-5.9%	14,823	TOTAL OTHER OPERATING REVENUE	173,782	175,061	(1,279)	-0.7%	151,110	
30,710	24,154	6,556	27.1%	24,760	TOTAL OPERATING REVENUE	309,093	291,862	17,231	5.9%	269,630	
OPERATING EXPENSES:						OPERATING EXPENSES:					
14,565	13,582	(983)	-7.2%	12,454	Personnel Services	169,591	162,988	(6,603)	-4.1%	154,242	
3,492	3,257	(235)	-7.2%	3,624	Mandatory Fringe Benefits	40,663	39,079	(1,584)	-4.1%	37,020	
8,608	8,358	(250)	-3.0%	8,468	Contractual Services	103,300	100,300	(3,000)	-3.0%	91,788	
3,059	2,100	(959)	-45.7%	2,148	Materials and Supplies (excl. Pharm.)	27,705	25,205	(2,500)	-9.9%	25,582	
1,042	1,167	125	10.7%	1,018	Pharmaceuticals	12,500	14,000	1,500	10.7%	12,621	
605	630	25	4.0%	514	Facilities Maintenance & Capital Outlay	7,262	7,562	300	4.0%	3,173	
1,314	1,455	141	9.7%	3,451	Services of Other Departments	15,769	17,461	1,692	9.7%	15,135	
(99)	(110)	(11)	-10.0%	(106)	Expenditure Recovery	(1,187)	(1,319)	(132)	-10.0%	(639)	
8,135	8,185	50	0.6%	8,185	Operating Transfer Out	97,625	98,225	600	0.6%	68,730	
427	427	0	n/a	187	Intrafund Transfer	5,129	5,129	0	n/a	2,248	
0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a	0	
551	635	84	13.2%	1,015	Continuing Projects	6,618	7,618	1,000	13.1%	5,047	
41,699	39,686	(2,013)	-5.1%	40,958	TOTAL OPERATING EXPENSES	484,975	476,248	(8,727)	-1.8%	414,947	
(10,989)	(15,532)	4,543	29.2%	(16,198)	OPERATING INCOME/(LOSS)	(175,882)	(184,386)	8,504	4.6%	(145,317)	
NON-OPERATING REVENUE:						NON-OPERATING REVENUE:					
8,020	8,020	0	n/a	6,757	General Fund	96,245	96,245	0	n/a	79,135	
5,093	5,093	0	n/a	5,093	Realignment	61,113	61,113	0	n/a	61,113	
285	285	0	n/a	247	Prop 99	3,423	3,423	0	n/a	3,102	
487	487	0	n/a	212	Transfer In and Project-Related	5,846	5,846	0	n/a	3,728	
1,207	1,207	0	n/a	1,425	Carryforward	14,482	14,482	0	n/a	(576)	
73	73	0	n/a	66	Cafeteria	877	877	0	n/a	758	
200	200	0	n/a	246	Miscellaneous	2,400	2,400	0	n/a	2,610	
15,365	15,365	0	n/a	14,046	TOTAL NON-OPERATING REVENUE	184,386	184,386	0	n/a	149,870	
4,376	(167)	4,543	2720.4%	(2,152)	NET INCOME/(LOSS)	8,504	0	8,504	n/a	4,553	

SAN FRANCISCO GENERAL HOSPITAL
SUMMARY STATISTICAL INFORMATION - FYE 6/30/2002
 Month Ending: APR 30, 2002

CURRENT MONTH						YEAR-TO-DATE					
Actual	Budget	Variance	% Var	Prior Year	KEY VOLUME INDICATORS	Actual	Budget	Variance	% Var	Prior Year	
<u>Discharges (incl. MHRF)</u>											
1,410	1,395	15	1.1%	1,330	Discharges (incl. MHRF)	14,370	14,242	128	0.9%	14,707	1
1,991	1,960	31	1.6%	1,862	Adjusted Discharges (incl. MHRF)	20,028	19,968	60	0.3%	20,733	2
<u>Average Daily Census</u>											
198	176	22	12.5%	188	Acute Med/Surg ADC	193	179	14	7.8%	191	3
91	91	(3)	-3.0%	90	Psych ADC	91	92	(2)	-1.6%	92	4
28	20	8	41.5%	27	Skilled Nursing ADC	27	20	7	34.5%	23	5
315	287	28	9.6%	305	Total ADC excl. MHRF	310	291	19	6.6%	306	6
140	140	(0)	-0.2%	139	MHRF ADC	139	140	(1)	-0.7%	137	7
454	427	27	6.4%	444	Total Adult ADC	449	431	18	4.2%	443	8
7	7	(2)	-32.9%	7	Nursery ADC	5	7	(2)	-28.6%	7	9
6.8	6.4	(0.4)	-6.2%	7.0	Average Length of Stay (excl. MHRF)	6.7	5.9	(0.8)	-13.6%	6.4	10
1.278	1.295	(0.017)	-1.3%	1.291	Medicare Case Mix Index	1.278	1.295	(0.017)	-1.3%	1.291	11
<u>Payor Mix (Gross Revenue)</u>											
50.6%	48.5%	2.1%	4.3%	40.4%	Medi-Cal	46.9%	48.5%	-1.6%	-3.3%	43.9%	12
19.6%	17.5%	2.1%	11.7%	18.3%	Medicare	17.8%	17.5%	0.3%	1.6%	18.3%	13
29.9%	34.0%	-4.1%	-12.1%	41.3%	Other	35.3%	34.0%	1.3%	3.9%	37.8%	14
100.0%	100.0%	0.0%	n/a	100.0%	Total	100.0%	100.0%	0.0%	n/a	100.0%	15
<u>Patient Days</u>											
6,287	4,528	1,759	38.8%	4,772	Medi-Cal Patient Days (excl. MHRF)	55,926	46,380	9,546	20.6%	48,911	16
2,206	1,952	254	13.0%	1,902	Medicare Patient Days (excl. MHRF)	21,304	19,993	1,311	6.6%	20,953	17
945	2,160	(1,215)	-56.3%	2,450	Other Patient Days (excl. MHRF)	17,301	22,124	(4,823)	-21.8%	23,058	18
9,438	8,640	798	9.2%	9,124	Total Patient Days(excl. MHRF)	94,531	88,497	6,034	6.8%	92,922	19
6,665	5,104	1,561	30.6%	5,128	Medi-Cal Patient Days	59,763	52,099	7,664	14.7%	54,347	20
2,206	2,001	205	10.2%	1,902	Medicare Patient Days	21,304	20,426	878	4.3%	20,953	21
4,758	5,734	(976)	-17.0%	6,262	Other Patient Days	55,725	58,528	(2,803)	-4.8%	59,159	22
13,629	12,839	790	6.2%	13,292	Total Patient Days	136,792	131,053	5,739	4.4%	134,459	23
19,244	18,040	1,204	6.7%	18,605	Adjusted Patient Days	190,616	183,756	6,860	3.7%	189,576	24
84.6%	79.5%	5.1%	6.4%	82.5%	% Occupancy (available beds)	83.7%	80.3%	3.4%	4.2%	82.5%	25
<u>KEY OPERATIONAL INDICATORS</u>											
<u>Labor</u>											
2,489.9	2,380.0	(109.9)	-4.6%	2,318.2	FTEs - Productive	2,389.3	2,380.0	(9.3)	-0.4%	2,268.3	26
233.8	329.0	95.2	28.9%	270.1	FTEs - Non-Productive	311.2	329.0	17.8	5.4%	332.6	27
2,723.7	2,709.0	(14.7)	-0.5%	2,588.3	Total FTEs - SFGH Only	2,700.5	2,709.0	8.5	0.3%	2,600.9	28
334	334	0	n/a	334	UC Non-Academic FTEs	334	334	0	n/a	334	29
3,058	3,043	(15)	-0.5%	2,922	Grand Total FTEs Incl. UC	3,035	3,043	9	0.3%	2,935	30
4.8	5.1	0.3	5.9%	4.7	FTEs Per AOB (incl. UC)	4.8	5.1	0.3	5.1%	4.7	31
\$ 63,463	\$ 60,126	(\$ 3,337)	-5.6%	\$ 59,958	Average Labor Cost per SFGH FTE	\$ 62,685	\$ 60,126	(\$ 2,559)	-4.3%	\$ 59,199	32
24.0%	23.9%	-0.1%	-0.4%	29.1%	Fringe Benefits as % of Salary	24.0%	24.0%	0.0%	n/a	23.9%	33
<u>Revenues</u>											
\$ 1,596	\$ 1,337	\$ 259	19.4%	\$ 1,369	Oper. Rev. Per Adjusted Patient Day (incl. MHRF)	\$ 1,352	\$ 1,323	\$ 29	2.2%	\$ 1,308	34
\$ 951	\$ 648	\$ 303	46.8%	\$ 693	Oper. Rev. (excl. SB855/1255/GME)/APD	\$ 701	\$ 646	\$ 55	8.5%	\$ 645	35
\$ 15,424	\$ 12,308	\$ 3,116	25.3%	\$ 13,676	Oper. Rev. Per Adjusted Discharge	\$ 12,867	\$ 12,171	\$ 696	5.7%	\$ 11,956	36
\$ 9,193	\$ 5,965	\$ 3,228	54.1%	\$ 6,927	Oper. Rev. (excl. SB855/1255/GME)/Adj. Discharge	\$ 6,673	\$ 5,945	\$ 728	12.2%	\$ 5,894	37
<u>Expenses</u>											
\$ 2,167	\$ 2,111	(\$ 56)	-2.7%	\$ 2,202	Operating Exp. Per Adjusted Pt. Day	\$ 2,109	\$ 2,087	(\$ 22)	-1.1%	\$ 1,995	38
\$ 1,744	\$ 1,657	(\$ 87)	-5.3%	\$ 1,762	Operating Exp.(excl. IGT)/Adj. Pt. Day	\$ 1,682	\$ 1,642	(\$ 40)	-2.4%	\$ 1,563	39
\$ 20,945	\$ 19,429	(\$ 1,516)	-7.8%	\$ 21,998	Operating Exp. Per Adj. Discharge	\$ 20,073	\$ 19,209	(\$ 864)	-4.5%	\$ 18,241	40
\$ 16,859	\$ 15,253	(\$ 1,606)	-10.5%	\$ 17,602	Operating Exp.(excl. IGT)/Adj. Discharge	\$ 16,011	\$ 15,110	(\$ 901)	-6.0%	\$ 14,293	41
24.1%	32.9%	8.8%	26.7%	31.9%	Supply Expense as % of Net Pt. Revenue	29.7%	32.7%	3.0%	9.2%	35.6%	42
81	80	(1)	-1.3%	99	Days Revenue in Accounts Receivable	81	80	(1)	-1.3%	99	43

0.458
/02
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HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor
Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, June 11, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

JUN 7 2002

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF MAY 14, 2002
**Minutes of May 14, 2002*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGHMC)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Officer)
**Report*
- 5) FOR DISCUSSION: FINANCE REPORT - STATEMENT OF REVENUES AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
**Report*

6) PUBLIC COMMENT**

7) CLOSED SESSION

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: APPROVAL OF CLOSED SESSION MINUTES
OF MAY 14, 2002

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT,
QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: CONSIDERATION OF CREDENTIALING MATTERS
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION
AND POSSIBLE
ACTION: MEDICAL STAFF REPORT
J. Renee Navarro, M.D., Chief of Staff

D) Reconvene in Open Session

- 1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
- 2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

8) ADJOURNMENT

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

* Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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1/02
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Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, June 11, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

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1) CALL TO ORDER

The San Francisco General Hospital Joint Conference Committee meeting was called to order by Commissioner Lee Ann Monfredini at 3:45 p.m.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

Staff: Wahid Choudhury, Myra Garcia, Phillip Hopewell, M.D.,
Seth Ingram, John Luce, M.D., Sharon McCole-Wicher,
Alison Moed, Gene O'Connell, Roland Pickens, Gregg Sass,
Hiroshi Tokubo, Chris Wachsmuth, Connie Young.

2) APPROVAL OF MINUTES OF MAY 14, 2002

Action Taken: The Committee approved the minutes of the May 14, 2002 San Francisco General Joint Conference Committee meeting.

3) HOSPITAL HEALTHCARE UPDATE

Gene O'Connell presented the Hospital Healthcare Update.

Program Updates

JCAHO Final Results and Next Steps

Last week, San Francisco General Hospital received the final findings and accreditation report from JCAHO. The final report does not differ significantly from the preliminary report given on the last day of the survey and the scores for all three surveys remain the same.

Prior to receiving the final report last week, Hiroshi Tokubo, Director of Quality Management, with the Associate Administrators had assigned each Type I to a member of the Executive Staff. In all, SFGH received nine (9) Type I's. SFGH has 30 days from the receipt date of the final report to appeal the Type I finding and will be appealing three (3) of the Type I's. Plan of Corrections will be created for the remaining six (6) Type I's and will be submitted to JCAHO by the deadline of December 4, 2002.

In addition to addressing the Type I's, the Executive Committee will be addressing the supplemental recommendations provided to us by JCAHO and will be developing internal action plans to address them.

Computerized Provider Order Entry (CPOE)

San Francisco General Hospital Medical Center is currently engaged in an effort to implement and introduce Computerized Provider Order Entry (CPOE) into the system. CPOE allows all diagnostic departments, pharmacy, nursing and other providers to work off one electronic set of prescriber orders. The benefit, which SFGH is particularly interested in, is the potential and ability of CPOE to improve patient safety, particularly in reducing medication errors. This was discussed at an earlier JCC-SFGH as part of SFGHMC's Plan to the California State Department of Health Services on how we would meet SB 1875. CPOE was mentioned within the SB 1875 action plan as a mechanisms we would utilize to decrease medication errors.

SFGHMC is currently in the planning stage in looking at CPOE. The Steering Committee and work groups have been established to determine how providers would like to customize CPOE and more importantly look at workflow issues. The Steering Committee is co-chaired by Robert Brody, M.D. and Sue Currin, R.N.

SFGH will be certain to continue to report into the JCC-SFGH as the CPOE project progresses.

Re-engineering Patient Access

Patient Financial Services is spearheading an effort to make patient registration easier for those who come to receive ambulatory services at SFGH. Back in July 2000, HCFA regulations mandated that the registration process be changed from monthly registration to per encounter visit, also known as episodic registration. In addition to creating additional work for Patient Financial Services, it also created more work for patients who would now have to receive a new registration card for every ambulatory visit. With the goal of making registration easier for everyone and increasing access for patients, a workgroup was formed with the charge of redesigning the appointment and registration processes on Invision, in order to facilitate and ease the flow of patient access to care providers and services.

Through a lot of work and coordination with Information Systems and Ambulatory Services, Patient Financial Services will soon be introducing a new permanent registration card to all ambulatory patients. This "swipe" card will have the ability to positively identify the patient in the computer system, reduce generation of duplicate medical record numbers, reduce the amount

of data entry, and overall will improve patient satisfaction by eliminating the need for each patient to receive a new card for each ambulatory visit.

SFGH looks forward to keeping the JCC-SFGH informed as the "live" date of the card in Winter 2002 approaches.

Announcements

Annual Medical Staff Dinner

The Annual Medical Staff Dinner will be held on Wednesday, June 12th at 6:00 p.m. in the Main Cafeteria. The Dinner is held each year to thank the medical staff for their hard work and dedication, as well as publicly acknowledge certain interns and residents for their outstanding work. It is also at this dinner/meeting that the new Chief of Staff-Elect will be announced. The Medical Staff elects the Chief of Staff-Elect into the position.

Departures

Ms. O'Connell announced that there will be two staff members leaving San Francisco General Hospital Medical Center over the next couple of months.

John Kanaley, Sr., Associate Administrator for Support Services, will be resigning effective July 5, 2002 to pursue a new opportunity with Kaiser in Santa Clara. In his new position, John will be responsible for overseeing the development and building of a new hospital.

Connie Young, Executive Assistant, will be resigning effective August 2, 2002 to relocate back to Boston. Connie has been here for four years, first joining DPH as the first and last CHN Administrative Fellow. Connie's husband, Rob, has just recently been accepted to Boston University for a 2-year Master in Business Administration and Master in Information Technology. Both Connie and Rob's immediate family are in the Boston area, prompting the difficult decision to move back to Boston.

Both John and Connie will be surely missed. Recruitment efforts for both of their positions is underway with the hope to fill these positions by early Fall 2002.

Commissioners' Comments

- Commissioner Umekubo asked if SFGH has contracted with a vendor for the Computer Provider Order Entry. Ms. O'Connell said that they have contracted with Siemens. However much of the work will be done through the use of volunteers and reallocating resources.
- Commissioner Monfredini asked that the Re-engineering Patient Access report be presented to the San Francisco General Hospital Joint Conference Committee.

4) PATIENT CARE REPORT

Sharon McCole-Wicher, Director of Nursing for Psychiatry, updated the committee on the CHN Patient Flow Committee. The purpose of the committee is to address the identified problem of reduced reimbursements at SFGH due to the inordinately high number of administrative and denied days and the higher cost of fee-for-service hospitalization due to a lack of capacity at SFGH.

In February 2002 the Director of Health established a goal to eliminate administrative days for SFGH Inpatient Psychiatry. The Patient Flow Committee was established with Barbara Garcia and Gene O'Connell as co-chairs. Two committees were created, one to deal with policy issues and the other with patient placement. The Placement Committee established four sub-committees. The Placement Committee is authorized to place patients at all levels of care at DPH. Weekly acuity rounds were initiated on inpatient units and inpatient units developed and implemented strategies to more aggressively review discharge plans and coordinate discharges. Inpatient units initiate early identification of patients with difficult problematic disposition issues.

Between March and May 2002 the placement committee achieved 59-64% reduction in administrative days per discharge. There was a 28% increase in admissions from January/February 2002. They also established a process for providing Utilization Review at all levels of care.

In May 2002 a Community Mental Health Services (CMHS) RN was based at SFGH to provide ongoing assessment, consultation with treatment teams and facilitation of patient placement. The RN is able to assess, make referrals and place a patient within a shift. In addition 50% of residential treatment beds were prioritized for acute inpatient and MHRF patients. PES achieved 100% compliance with referral of all SF Medi-Cal to SFGH. The Residential Discharge Committee met daily with representatives of acute and residential treatment programs, and the referral process efficiency increased. Also in May was the suspension of Bed Committee referrals, and the decision that inpatient UR be completed by SFGH staff.

Ms. McCole-Wicher presented a comparison of costs associated with administrative days, comparing May 2001 with May 2002, as well as cost savings associated with non-use of fee-for-service hospitals.

Ms. O'Connell stated that this effort has been a true collaboration that has been successful because of the people working on it. She added that the effort is about quality of care for the patients they serve, not just about cost.

Commissioners' Comments

- Commissioner Umekubo asked about the process for determining administrative and denied days. Community Mental Health Services (CMHS), as dictated by the State's one-plan model, is responsible for review, with an annual audit. Previously both UC and CMHS had done UR at the hospital. Under the new process UC will do UR at the hospital and CMHS will now be able to do UR at other levels of care.
- Commissioner Monfredini asked what happens on the weekend when the CMHS RN is not on duty. Ms. McCole-Wicher replied that there are social workers on staff on the weekend. In addition, many discharge packets are prepared in advance of the weekend.

5) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES

Gregg Sass presented the Finance Report (Attachment A).

Commissioners' Comment

- Commissioner Umekubo said it seems that staff has a handle on pharmacy costs, and asked if this was the case. Mr. Sass replied that it was, since much of the costs are in the PBM

contract. He added that Inpatient Pharmacy is under budget, which is partially a result of rebate programs. Ms. O'Connell commended Sharon Kotabe for all of her efforts.

6) **PUBLIC COMMENT**

None.

7) **CLOSED SESSION**

A) **Public Comments on All Matters Pertaining to the Closed Session**

None.

B) **Vote on Whether to Hold a Closed Session**

Action Taken: The Committee voted to hold a closed session.

The Committee went into closed session at 4:40 p.m. Present in closed session were the same people who were present in open session with the exception of Gregg Sass and Wahid Choudhury.

C) **Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1**

APPROVAL OF CLOSED SESSION MINUTES OF MAY 14, 2002

Action Taken: The Committee approved the closed session minutes of May 14, 2002.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

CONSIDERATION OF CREDENTIALING MATTERS

Action Taken: The Committee approved the credentials report.

MEDICAL STAFF REPORT

D) **Reconvene in Open Session**

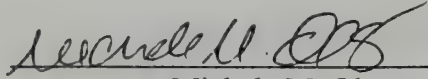
The Committee reconvened in open session at 5:20 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any and all discussions held in closed session.

8) ADJOURNMENT

The meeting was adjourned at 5:21 p.m.

A handwritten signature in dark ink, appearing to read "Michele M. Olson", is written over a horizontal line.

Michele M. Olson
Executive Secretary to the Health Commission

Attachment (1)

San Francisco General Hospital
STATEMENT OF REVENUE AND EXPENSES - FYE 6/30/02
 Month Ending: MAY 31, 2002
 (In Thousands of Dollars)

MONTHLY					ANNUAL				
Fav/(Unfav)					Fav/(Unfav)				
Projection	Budget	Variance	% Var.	PY Actual	Projection	Budget	Variance	% Var.	PY Actual
GROSS PATIENT REVENUE:									
16,851	14,371	2,480	17.3%	11,724	Inpatient Medi-Cal Revenue	194,614	153,066	41,548	27.1%
4,612	4,820	(208)	-4.3%	4,321	Outpatient Medi-Cal Revenue	51,184	50,488	696	1.4%
6,426	5,040	1,386	27.5%	5,620	Inpatient Medicare Revenue	69,632	63,169	6,463	10.2%
2,177	1,897	280	14.8%	2,013	Outpatient Medicare Revenue	24,078	23,382	696	3.0%
8,245	8,658	(413)	-4.8%	11,630	Inpatient Other Revenue	110,645	117,428	(6,783)	-5.8%
6,234	4,787	1,447	30.2%	5,718	Outpatient Other Revenue	72,770	63,876	8,894	13.9%
44,545	39,573	4,972	12.6%	41,026	TOTAL PATIENT SERVICE REVENUE	522,923	471,409	51,514	10.9%
REVENUE DEDUCTIONS:									
4,894	6,555	1,661	25.3%	9,006	Charity Care	61,999	80,100	18,101	22.6%
16,195	14,710	(1,485)	-10.1%	11,923	Provision for Medi-Cal Adjustments	185,468	154,844	(30,624)	-19.8%
4,281	2,496	(1,785)	-71.5%	3,612	Provision for Medicare Adjustments	46,636	42,646	(3,990)	-9.4%
5,566	3,950	(1,616)	-40.9%	7,270	Provision for Other Adjustments	70,509	54,518	(15,991)	-29.3%
5,450	2,057	(3,393)	-164.9%	(1,750)	Provision for Bad Debt	26,400	22,500	(3,900)	-17.3%
36,386	29,768	(6,618)	-22.2%	30,061	TOTAL REVENUE DEDUCTIONS	391,012	354,608	(36,404)	-10.3%
8,159	9,805	(1,646)	-16.8%	10,965	NET PATIENT SERVICE REVENUE	131,911	116,801	15,110	12.9%
OTHER OPERATING REVENUE:									
710	710	0	n/a	705	Capitation/Managed Care Settlement	8,519	8,519	0	n/a
379	421	(42)	-10.0%	388	Short Doyle	4,554	5,054	(500)	-9.9%
10,656	10,515	141	1.3%	10,626	SB855	127,867	126,183	1,684	1.3%
1,642	1,808	(166)	-9.2%	1,833	SB1255	19,700	21,700	(2,000)	-9.2%
108	108	0	n/a	108	GME	1,300	1,300	0	n/a
594	660	(66)	-10.0%	830	Revenue from Other City Departments	7,132	7,924	(792)	-10.0%
3,463	0	3,463	n/a	(34)	Prior Year Settlement	4,174	0	4,174	n/a
333	365	(32)	-8.8%	333	MAA & Other Net Patient Revenue	4,000	4,381	(381)	-8.7%
17,885	14,587	3,298	22.6%	14,789	TOTAL OTHER OPERATING REVENUE	177,246	175,061	2,185	1.2%
26,044	24,392	1,652	6.8%	25,754	TOTAL OPERATING REVENUE	309,157	291,862	17,295	5.9%
OPERATING EXPENSES:									
15,091	13,582	(1,509)	-11.1%	13,704	Personnel Services	169,591	162,988	(6,603)	-4.1%
3,618	3,257	(361)	-11.1%	3,278	Mandatory Fringe Benefits	40,663	39,079	(1,584)	-4.1%
8,608	8,358	(250)	-3.0%	8,365	Contractual Services	103,300	100,300	(3,000)	-3.0%
2,309	2,100	(209)	-10.0%	2,148	Materials and Supplies (excl. Pharm.)	27,705	25,205	(2,500)	-9.9%
1,042	1,167	125	10.7%	1,250	Pharmaceuticals	12,500	14,000	1,500	10.7%
605	630	25	4.0%	517	Facilities Maintenance & Capital Outlay	7,262	7,562	300	4.0%
1,473	1,455	(18)	-1.2%	1,374	Services of Other Departments	15,943	17,461	1,518	8.7%
(99)	(110)	(11)	-10.0%	(106)	Expenditure Recovery	(1,187)	(1,319)	(132)	-10.0%
8,135	8,185	50	0.6%	8,185	Operating Transfer Out	97,625	98,225	600	0.6%
427	427	0	n/a	187	Intrafund Transfer	5,129	5,129	0	n/a
0	0	0	n/a	0	SB1255 and GME IGT	0	0	0	n/a
(274)	635	909	143.1%	428	Continuing Projects	5,718	7,618	1,900	24.9%
40,935	39,686	(1,249)	-3.1%	39,330	TOTAL OPERATING EXPENSES	484,249	476,248	(8,001)	-1.7%
(14,891)	(15,294)	403	2.6%	(13,576)	OPERATING INCOME/(LOSS)	(175,092)	(184,386)	9,294	5.0%
NON-OPERATING REVENUE:									
8,020	8,020	0	n/a	6,757	General Fund	96,245	96,245	0	n/a
5,093	5,093	0	n/a	5,093	Realignment	61,113	61,113	0	n/a
285	285	0	n/a	336	Prop 99	3,423	3,423	0	n/a
487	487	0	n/a	374	Transfer In and Project-Related	5,846	5,846	0	n/a
1,207	957	250	26.1%	821	Carryforward	14,482	14,482	0	n/a
73	73	0	n/a	64	Cafeteria	877	877	0	n/a
200	200	0	n/a	339	Miscellaneous	2,400	2,400	0	n/a
15,365	15,115	250	1.7%	13,784	TOTAL NON-OPERATING REVENUE	184,386	184,386	0	n/a
474	(179)	653	364.8%	208	NET INCOME/(LOSS)	9,294	0	9,294	n/a

San Francisco General Hospital
SUMMARY STATISTICAL INFORMATION - FYE 6/30/01
Month Ending: MAY 31, 2002

CURRENT MONTH						YEAR-TO-DATE					
Actual	Budget	Variance	% Var	Prior Year	KEY VOLUME INDICATORS	Actual	Budget	Variance	% Var	Prior Year	
					<u>Discharges (incl. MHRF)</u>						
1,566	1,425	141	9.9%	1,469	Discharges (incl. MHRF)	15,936	15,667	269	1.7%	16,176	1
2,213	2,009	204	10.2%	2,080	Adjusted Discharges (incl. MHRF)	22,241	21,977	264	1.2%	22,813	2
					<u>Average Daily Census</u>						3
189	171	18	10.2%	185	Acute Med/Surg ADC	193	178	15	8.1%	190	4
86	92	(6)	-7.0%	92	Psych ADC	91	92	(1)	-1.5%	92	5
28	20	8	37.5%	25	Skilled Nursing ADC	27	20	7	35.0%	23	6
302	283	19	6.6%	302	Total ADC excl. MHRF	310	290	20	6.9%	305	7
140	140	(0)	-0.3%	140	MHRF ADC	139	140	(1)	-0.6%	137	8
441	423	18	4.3%	442	Total Adult ADC	449	430	19	4.5%	442	9
7	7	(0.4)	-5.7%	7	Nursery ADC	7	7	0.0	n/a	7	10
6.1	6.4	0.3	4.7%	6.4	Average Length of Stay (excl. MHRF)	6.6	6.0	(0.6)	-10.0%	6.4	11
					<u>Medicare Case Mix Index</u>						12
1.279	1.295	0.016	1.3%	1.304		1.279	1.295	0.016	1.3%	1.304	13
					<u>Payor Mix (Gross Revenue)</u>						14
48.2%	48.5%	-0.3%	-0.7%	39.1%	Medi-Cal	47.0%	48.5%	-1.5%	-3.1%	43.4%	15
19.3%	17.5%	1.8%	10.3%	18.6%	Medicare	17.9%	17.5%	0.4%	2.4%	18.3%	16
32.5%	34.0%	-1.5%	-4.4%	42.3%	Other	35.1%	34.0%	1.1%	3.1%	38.3%	17
100.0%	100.0%	0.0%	n/a	100.0%	Total	100.0%	100.0%	0.0%	0.0%	100.0%	18
					<u>Patient Days</u>						19
5,536	4,598	1,038	22.6%	4,680	Medi-Cal Patient Days (excl. MHRF)	61,562	50,978	10,584	20.8%	53,591	20
2,239	1,982	257	13.0%	2,043	Medicare Patient Days (excl. MHRF)	23,543	21,975	1,568	7.1%	22,996	21
1,474	2,193	(719)	-32.8%	2,623	Other Patient Days (excl. MHRF)	18,775	24,317	(5,542)	-22.8%	25,681	22
9,349	8,773	576	6.6%	9,346	Total Patient Days(excl. MHRF)	103,880	97,270	6,610	6.8%	102,268	23
					<u>Medi-Cal Patient Days</u>						24
5,957	5,213	744	14.3%	4,958	Medi-Cal Patient Days	65,720	57,312	8,408	14.7%	59,305	25
2,239	2,044	195	9.5%	2,043	Medicare Patient Days	23,543	22,470	1,073	4.8%	22,996	26
5,481	5,856	(375)	-6.4%	6,680	Other Patient Days	61,206	64,384	(3,178)	-4.9%	65,839	27
13,677	13,113	564	4.3%	13,681	Total Patient Days	150,469	144,166	6,303	4.4%	148,140	28
19,327	18,487	840	4.5%	19,371	Adjusted Patient Days	209,943	202,243	7,700	3.8%	208,947	29
					<u>% Occupancy (available beds)</u>						30
82.2%	78.8%	3.4%	4.3%	82.1%		83.6%	80.1%	3.5%	4.4%	82.3%	31
					<u>KEY OPERATIONAL INDICATORS</u>						32
					<u>Labor</u>						33
2,452.3	2,380.0	(72.3)	-3.0%	2,361.4	FTEs - Productive	2,395.0	2,380.0	(15.0)	-0.6%	2,276.8	34
257.7	329.0	71.3	21.7%	241.9	FTEs - Non-Productive	306.3	329.0	22.7	6.9%	324.3	35
2,710.0	2,709.0	(1.0)	0.0%	2,603.4	Total FTEs - SFGH Only	2,701.3	2,709.0	7.7	0.3%	2,601.1	36
334.0	334.0	0.0	n/a	334.0	UC Non-Academic FTEs	334.0	334.0	0.0	n/a	334.0	37
3,044.0	3,043.0	(1.0)	0.0%	2,937.4	Grand Total FTEs Incl. UC	3,035.3	3,043.0	7.7	0.3%	2,935.1	38
4.9	5.1	0.2	3.9%	4.7	FTEs Per AOB (incl. UC)	4.8	5.1	0.3	5.0%	4.7	39
\$ 64,167	\$ 60,126	(\$4,041)	-6.7%	\$60,930	Average Labor Cost per SFGH FTE	\$ 62,820	\$60,126	(\$2,694)	-4.5%	\$ 59,356	40
24.0%	23.9%	-0.1%	-0.4%	23.9%	Fringe Benefits as % of Salary	24.0%	24.0%	0.0%	n/a	23.9%	41
					<u>Revenues</u>						42
\$ 1,160	\$ 1,318	(\$158)	-12.0%	\$1,366	Oper. Rev. Per Adjusted Patient Day (incl. MHRF)	\$ 1,334	\$1,322	\$12	0.9%	\$1,313	43
\$ 518	\$ 645	(\$127)	-19.7%	\$717	Oper. Rev. (excl. SB855/1255/GME)/APD	\$ 684	\$646	\$38	5.9%	\$651	44
\$ 10,127	\$ 12,126	(\$1,999)	-16.5%	\$12,721	Oper. Rev. Per Adjusted Discharge	\$ 12,594	\$12,167	\$427	3.5%	\$12,026	45
\$ 4,521	\$ 5,938	(\$1,417)	-23.9%	\$6,678	Oper. Rev. (excl. SB855/1255/GME)/Adj. Discharge	\$ 6,459	\$5,944	\$515	8.7%	\$5,966	46
					<u>Expenses</u>						47
\$ 2,118	\$ 2,111	(\$7)	-0.3%	\$2,030	Operating Exp. Per Adjusted Pt. Day	\$ 2,110	\$2,089	(\$21)	-1.0%	\$1,998	48
\$ 1,697	\$ 1,668	(\$29)	-1.7%	\$1,608	Operating Exp.(excl. IGT)/Adj. Pt. Day	\$ 1,684	\$1,644	(\$40)	-2.4%	\$1,567	49
\$ 18,498	\$ 19,424	\$926	4.8%	\$18,909	Operating Exp. Per Adj. Discharge	\$ 19,916	\$19,229	(\$687)	-3.6%	\$18,302	50
\$ 14,822	\$ 15,349	\$527	3.4%	\$14,974	Operating Exp.(excl. IGT)/Adj. Discharge	\$ 15,893	\$15,132	(\$761)	-5.0%	\$14,355	51
41.1%	33.1%	-8.0%	-24.2%	31.0%	Supply Expense as % of Net Pt. Revenue	30.5%	32.7%	2.2%	6.7%	35.1%	52
77	80	3	3.8%	84	Days Revenue in Accounts Receivable	77	80	3	3.8%	84	53

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02
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Vice President

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Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor

Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, July 9, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

JUL 3 2002

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- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF JUNE 11, 2002
**Minutes of June 11, 2002*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGHMC)
(Gene O'Connell, Executive Administrator, San Francisco
General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Officer)
**Report*
- 5) FOR DISCUSSION: FINANCE REPORT - STATEMENT OF REVENUES
AND EXPENDITURES
(Gregg Sass, CHN Chief Financial Officer)
**Report*

- 6) **FOR DISCUSSION:** **UPDATE ON THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH LONG RANGE SERVICE DELIVERY PLANNING PROJECT**
(Anthony Wagner, Chief Executive Officer of Hospital Systems
(Update)

- 7) **FOR DISCUSSION:** **PUBLIC COMMENT****

- 8) **CLOSED SESSION**

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **APPROVAL OF CLOSED SESSION MINUTES OF JUNE 11, 2002**

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE**

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: **CONSIDERATION OF CREDENTIALING MATTERS**
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION AND POSSIBLE ACTION: **MEDICAL STAFF REPORT**
J. Renee Navarro, M.D., Chief of Staff

- D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

- 8) **ADJOURNMENT**

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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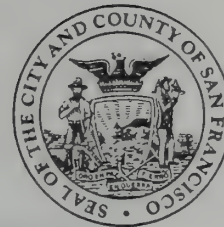
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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, July 9, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

SEP 9 2002

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1) CALL TO ORDER

The San Francisco General Hospital Joint Conference Committee meeting was called to order by Commissioner Lee Ann Monfredini at 3:45 p.m.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.
Commissioner Edward Chow, M.D.

Staff: Wahid Choudhury, Sue Currin, Rowena Esquieres, Myra Garcia, Mozettia Henley, Fred Hom, Seth Ingram, John Kanaley, Talmadge King, M.D., Sharon Kotabe, John Luce, M.D., Robert MacKersie, M.D., J. Renee Navarro, M.D., Sharon McCole-Wicher, Lisa Menendes, Kathy Murphy, J.D., Anson Moon, Gene O'Connell, Robert Okin, M.D., Roland Pickens, Gregg Sass, William Tausch, M.D., Hiroshi Tokubo, Chris Wachsmuth, Anthony Wagner, Connie Young

2) APPROVAL OF MINUTES OF JUNE 11, 2002

Action Taken: The Committee approved the minutes of the June 11, 2002 San Francisco General Joint Conference Committee meeting. Commissioner Monfredini also noted that Agenda Item #6, Update on the San Francisco Department of Public Health Long Range Service Delivery Planning Project, will be

presented at 4:30 p.m. to enable Lewin and Associates consultant, Keith Hearle, to be available to present the item.

3) HOSPITAL HEALTHCARE UPDATE

Gene O'Connell presented the Hospital Healthcare Update.

Program Updates

JCAHO Type I Appeals

After much planning and assistance, the Executive Committee has decided to appeal eight (8) of the twelve Type I's received from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The appeals for the eight Type I's were submitted to JCAHO on Friday, July 5th. The original deadline for the appeals was July 4, 2002; however, after consultation with JCAHO, it was decided that the appeals be submitted by July 8th, since the JCAHO offices were scheduled to be closed July 4th-July 7th and therefore may not have persons on-site to accept the appeals packet.

The eight Type I's which were submitted to be appealed are:

- RI.1.2 – Patient Rights/Trauma Videotaping
- RI.1.2.5 – Patient Rights/Advance Directives
- PE.1.2 – Nutrition Assessment
- TX.1.2 – Interdisciplinary Care Plans
- TX.3.5 – Appropriate Control of Medications
- EC.2.10.3 – Medical Equipment
- HR.5 – Human Resources/Age-Specific Competencies
- IM.7.8 – Authentication of Reports by Author

The four remaining Type I's that are not being appealed are:

- PE.1.4 – Pain
- EC.1.1.2 – Smoking
- IM.7.7 – Verbal Orders
- PE.2.1.7 – (MHRF)- Assessment of Prior Hobbies.

These four remaining Type I's will require submission of plans of corrections to JCAHO by December 4th, 2002.

SFGH looks forward to JCAHO's response on the outcome of the eight appeals. In the meanwhile, the Executive Committee will continue to work on all Type I's and Supplemental Recommendations to ensure progress is further achieved in the action plans developed for each of them.

Avon Foundation Comprehensive Breast Care Center

On July 1st, the Board of Supervisors unanimously passed the resolution for the City and County to: 1) to accept capital equipment and Avon Products Foundation grant funds from the SFGH Foundation; 2) build a breast center on SFGHMC campus; and 3) to name the breast center the "Avon Foundation Comprehensive Breast Center."

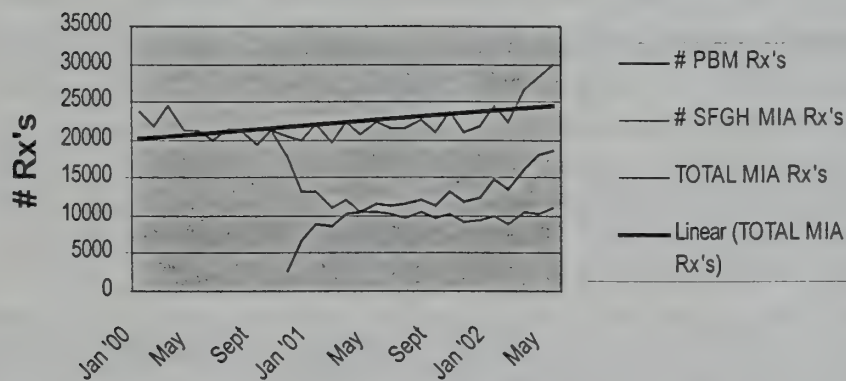
Groundbreaking for the *Avon Foundation Comprehensive Breast Center* will take place on Wednesday, July 10th at 10:30 a.m. in the Green Room, Veteran's Building, 401 Van Ness Avenue, Second Floor, San Francisco.

SFGH is honored to hear that both Supervisor Sophie Maxwell and Actress Sharon Stone will be present as special guests at the groundbreaking. SFGH hopes that the Health Commission will join on this special day.

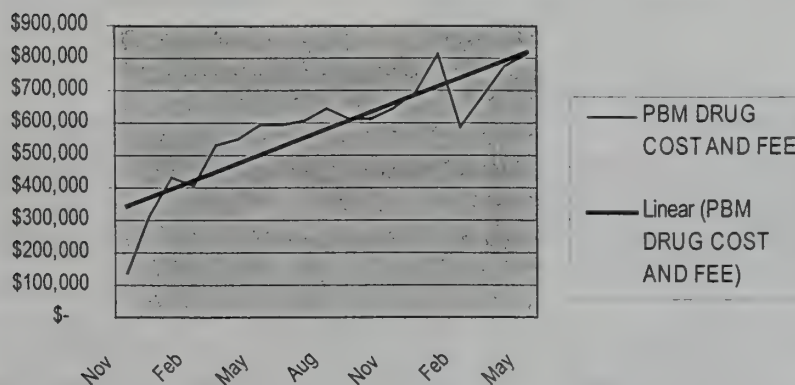
Pharmacy and PBM Update – July 2002

Utilization of prescription services provided through PBM continues to increase, with approximately 70% of prescriptions currently being filled by PBM network pharmacies and 30% by the SFGH pharmacy. Total volume of prescriptions filled per month also continues to increase. However, some of this increase may be due to the change in policy implemented February 2002, limiting refill quantities to 30-day instead of 90-day supplies. As might be expected by increased utilization and volume, costs of providing this benefit have also risen.

Prescription Volume/Utilization



PBM DRUG COST



Two avenues to contain costs of providing expanded access to prescription services are being actively pursued and investigated.

- ◆ SB 340, which went into effect January 2002, allows FQHC clinics to contract with a single pharmacy to provide prescriptions to clinic patients at the lowest prices offered by drug manufacturers. Although this will decrease access when compared to the current system, patients will still be able to receive prescription services near their primary care clinic, and the Department will be able to lower its prescription benefit costs.

One current barrier to implementation of this model is the reluctance of San Francisco area community pharmacies to participate in this type of arrangement. The reluctance stems from interpretation of the regulations such as requiring physically separated inventories. A pharmacy workgroup has been formed to determine whether this interpretation is accurate, and whether other real or imagined barriers exist among community pharmacies that might participate in this type of arrangement. As the entity eligible for the lowest manufacturer drug costs available through this model, the Department will be held accountable to establish safeguards and audits to protect against drug diversion. To be prepared to proceed with this model if feasible, the workgroup is therefore also charged to develop the safeguards and audits, as well as other systems, processes and procedures necessary for implementation. The workgroup has targeted November 2002 for completion of its charge.

- ◆ The Department submitted a demonstration project proposal to the Office of Pharmacy Affairs (OPA) in October 2000. That proposal was initially rejected, on the grounds that the proposed rebate-model for the expanded access PBM model was not within the purview of OPA to approve. Several discussions were held with OPA representatives in 2001 and 2002 to educate them about SFGH organization and mission, the proposed PBM and rebate model, and why it is believed it fell within the purview of OPA to approve the plan. With the passage of SB 340 in California, however, options for other models that could be proposed and that OPA might be less inclined to reject became available to SFGH. SFGH's original proposal is therefore being modified to take advantage of these new options. The modified proposal will maintain the original concept of the widest access possible through use of a PBM-model pharmacy network, and will not rely on a rebate structure for cost-savings realization. The opinion of OPA representatives of the concept for the revised proposal will be sought in a meeting in Washington, D.C. in July 2002. The revised proposal is scheduled for completion by the end of the summer with submission to OPA by October 2002.

AeroMedical Access Needs Assessment and Feasibility Study

The consulting contract to conduct the SFGH Trauma Center aeromedical access needs assessment and feasibility study is currently in the award process with the architect firm of Gerson/Overstreet. The DPH Contracts Office is working with Trauma Center staff and the Gerson/Overstreet team of aeromedical experts to craft the contract to answer questions related to patient care needs for this service and the feasibility of locating a helipad at the SFGH Campus.

SFGH anticipated to calendar the contract for approval before the Health Commission during August with a contract work start date planned for September. The work plan to conduct the aeromedical needs assessment and SFGH feasibility study is anticipated to take 5-6 months to complete. SFGH will continue to update the Commission on the feasibility study with an anticipated completion date of late winter 2003.

Impact of St. Luke's changes in services to SFGH

On Sunday, July 7th, St. Luke's decided to close their Emergency Department in anticipation of a one-day strike from the California Nurses Association, scheduled for July 17th, without providing the required 90-day notice to the State Department of Health Services (DHS). St. Luke's was ordered by DHS to reopen their Emergency Department today, July 9th, by 7:00 a.m.

San Francisco General Hospital was notified this morning by St. Luke's that even though the Emergency Department would be opened this morning at 7:00 a.m., St. Luke's would not be admitting any pediatric, obstetric, or psychiatric patients. St. Luke's also called a second time to inquire about SFGH's bed capacity even though they had no identified patients for transfer at the time of the call.

Since the St. Luke's Emergency Department closure, DHS has requested that SFGH track all St. Luke patients who have presented to SFGH's Emergency Department for treatment. SFGH will continue to monitor the situation and respond to all DHS requests.

Announcements

New Chief of Staff-Elect

The Medical Staff has selected a new Chief of Staff-Elect. Valerie Ng, Chief of Clinical Laboratories and Professor of Clinical Laboratory Medicine and Interim Chair for the UCSF Department of Laboratory Medicine, will begin serving as the Chief of Staff beginning FY 2003-04. During her period as Chief of Staff-Elect, she will be working closely with J. Renee Navarro, current Chief of Staff, to become oriented to the new role.

John Kanaley to Stay

After much consideration and negotiation, John Kanaley has decided to stay at San Francisco General Hospital Medical Center. As reported in last month's JCC-SFGH report, John Kanaley had accepted a position at Kaiser-Santa Clara to oversee the rebuild of their new hospital.

The Executive Committee and staff were deeply affected by John's announcement and over a course of a week were able to convince him to stay. San Francisco General Hospital Medical Center is elated with his decision to stay. His ongoing leadership, along with the leadership of the rest of the Executive Committee, will enable SFGH to achieve more this year than during the previous year.

4) PATIENT CARE REPORT

Sue Currin, RN, MS, Chief Nursing Office, presented the following report"

Nurse Management Professional Development

The SFGH Foundation facilitated the funding of a Nursing Management Professional Development Program, through the San Francisco Foundation, in the amount of \$30,000. Based on a national search for professional development options, the Institute for Johns Hopkins Nursing "Nurse Manager Academy" was identified as the best match for SFGH staff needs. The six-day intensive program includes a self-assessment as the basis for development as a leader, and includes workshops on human resource management, financial management, role integration for nurse managers, and negotiation/conflict management. In the first year, SFGH will send six nurse managers for training at Johns Hopkins. In the second and third years of the program, SFGH will request additional funding to develop a local program to provide this educational opportunity to 20-25 participants per year.

Private Industry Council

SFGHMC, through Leslie Holpit, Manager of Nursing Retention and Recruitment, is participating in a collaborative effort with the San Francisco Private Industry Council, San Mateo Workforce Investment Board, Local 250, Jewish Vocational Services, City College of San Francisco, San Mateo College, and local hospitals, to respond to a solicitation for proposals for the California Nurse Workforce Initiative (NWI). The NWI award (\$1.5 million) if awarded, will be used for LVN to RN training, LVN training and nursing prerequisite course completion for incumbent nursing employees. This 3-year grant will provide educational counseling and case management services for participants. Proposals are due July 31 and award announcements will be made August 30, 2002.

Recruitment and Retention Activities

Several training programs are scheduled to start in July 2002. A total of 33 nursing staff have been hired into permanent and per diem positions.

Med-Surg Training Program

6 MEPNs
4 LVNs
10 RNs

ED Training Program

6 RNs

Critical Care Training Program

6 RNs
1 LVN

Diversion Summary Report San Francisco General Hospital Diversion Report June 2002

EXECUTIVE SUMMARY

The Emergency Department [ED] recorded 37 episodes of diversion for 186 hours representing a rate of 26% in June 2002. This is a 5% decrease in diversion since May 2002.

The 37 episodes of diversion are categorized as follows:

Diversion Type	Number of Episodes	Hours	Rate	% Change from Previous Month
Total diversion	37	186	26	5
Trauma override	0	0	0	1%

The ED was impacted by capacity and high patient acuity during the episodes of total diversion. During this time, 187 patients were awaiting admission to in-patient beds [ICU-16, 4B/StepDown-74, MedSurg-98]. In June 2001, the ED was on diversion 24% of the month. Trauma Override was invoked 1.2% of the month in June 2001.

Total diversion was recorded for 37 episodes, a total of 186 hours or a 26% rate for June 2002, and a 5% decrease in total diversion since May 2002. While on Total Diversion the ED held 187 patients in June 2002. While on Total Diversion in June 2001, the ED held 187 patients awaiting inpatient beds.

Trauma override was not recorded for June 2002. This is a 1% decrease in trauma override since May 2002. While on Trauma override in June 2001, the ED held 26 patients awaiting inpatient beds.

Definitions:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999.

- A 911 is a critical trauma patient.
- A 912 is a potentially critical trauma patient.
- A 910 is a critical pediatric patient.
- Finally, a 999 is a multiple casualty incident involving three or more critical trauma patient.

EMSS Definitions:

Total Diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Communication Center.

Trauma Override:

When SFGH continues Total Diversion during a period of Total Diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/treatment in the SFGH trauma care system.

Prepared by: Sharon Kennedy R.N.
Base Hospital Coordinator

San Francisco General Hospital
Emergency Department
June 2002

Total Diversion Summary

In June, the Emergency Department recorded 37 episodes of Total Diversion for 186 hours, a percentage of 26% for the month.

Date	Length	Summary of Event
06/02/02	1655-2050 (3h 55m)	37 patients in the ED Admits: 1-4B; 1-Floor ED waiting room: 1 urgent patient
06/03/02	1430-1610 (1h 30m)	38 patients in the ED Admits: 2-4B ED waiting room: 15 urgent patients
6/03/02	2225-0230 (4h 5m)	33 patients in the ED Admits: 1-ICU; 1-4B; 1-Floor ED waiting room: 10 urgent patients
06/04/02	1530-1705 (1h 35m)	36 patients in the ED Admits: 1-4B; 2-Floor ED waiting room: 6 urgent patients
06/05/02	1120-1840 (7h 20m)	37 patients in the ED Admits: 2-4B ED waiting room: 13 urgent patients
06/05/02	1930-0345 (8h 15m)	30 patients in the ED Admits: 1-ICU; 1-4B; 4-Floor ED waiting room: 7 urgent patients
06/06/02	1830-2200 (3h 30m)	29 patients in the ED Admits: 3-4B; 3-Floor ED waiting room: 29 urgent patients
06/07/02	0000-0610 (6h 10m)	37 patients in the ED Admits: 3-4B; 2-Floor ED waiting room: 12 urgent patients
06/07/02	1730-0300 (9h 30m)	39 patients in the ED Admits: 2-4B; 8-Floor ED waiting room: 9 urgent patients
06/09/02	0040-0555 (5h 15m)	33 patients in the ED Admits: 2-4B; 4-Floor ED waiting room: 4 urgent patients
06/10/02	0205-0405 (2h)	30 patients in the ED Admits: 1-4B; 5-Floor ED waiting room: 4 urgent patients
06/10/02	1420-1935 (5h 15m)	36 patients in the ED Admits: 1-4B ED waiting room: 6 urgent patients

06/11/02	0103-0620 (5h 17m)	35 patients in the ED Admits: 4-4B; 4-Floor ED waiting room: 12 urgent patients
06/11/02	1117-1320 (2h 3m)	34 patients in the ED Admits: 3-ICU; 1-4B; 1-Floor ED waiting room: 4 urgent patients
06/11/02	1624-0615 (13h 51m)	38 patients in the ED Admits: 3-4B; 1-Floor ED waiting room: 7 urgent patients
06/12/02	1550-0748 (15h 48)	37 patients in the ED Admits: 2-4B; 1-Floor ED waiting room: 4 urgent patients
06/13/02	1330-1630 (3h)	33 patients in the ED Admits: 2-4B; 1-Floor ED waiting room: 4 urgent patients
06/14/02	1440-1640 (2h)	33 patients in the ED Admits: 6-Floor ED waiting room: 9 urgent patients
06/15/02	1920-2050 (1h 30m)	30 patients in the ED Admits: 1-ICU; 3-4B; 2-Floor ED waiting room: 3 urgent patients
06/16/02	2100-0125 (4h 25m)	36 patients in the ED Admits: 1-ICU; 4-4B ED waiting room: 6 urgent patients
06/17/02	1720-0235 (9h 15m)	37 patients in the ED Admits: 1-ICU, 1-4B, 2-Floor ED waiting room: 3 urgent patients
06/18/02	1337-1418 (51m)	32 patients in the ED Admits: 2-ICU ED waiting room: 7 urgent patients
06/18/02	1802-2215 (4h 13m)	35 patients in the ED Admits: 2-4B; 2-Floor ED waiting room: 7 urgent patients
06/19/02	1440-1850 (4h 10m)	36 patients in the ED Admits: 2-4B; 2-Floor ED waiting room: 4 urgent patients
06/19/02	2225-0440 (6h 15m)	33 patients in the ED Admits: 1-ICU; 8-Floor ED waiting room: 6 urgent patients
06/21/02	2130-0057 (3h 27m)	36 patients in the ED Admits: 1-ICU; 1-4B; 4-Floor ED waiting room: 8 urgent patients
06/22/02	2030-2230 (2h)	36 patients in the ED Admits: 1-4B; 4-Floor ED waiting room: 7 urgent patients
06/23/02	0000-0300 (3h)	26 patients in the ED Admits: 2-ICU; 2-4B; 5-Floor ED waiting room: 10 urgent patients

06/23/02	2300-0100 (2h)	30 patients in the ED Admits: 3-4B; 3-Floor ED waiting room: 4 urgent patients
06/24/02	1706-2150 (4h 44m)	40 patients in the ED Admits: 4-4B; 1-Floor ED waiting room: 17 urgent patients
06/25/02	1430-0200 (11h 30m)	35 patients in the ED Admits: 1-ICU; 3-4B; 1-Floor ED waiting room: 7 urgent patients
06/26/02	1430-1720 (2h 50m)	34 patients in the ED Admits: 4-4B; 1-Floor ED waiting room: 12 urgent patients
06/26/02	2115-0215 (5h)	35 patients in the ED Admits: 5-4B; 3-Floor ED waiting room: 9 urgent patients
06/27/02	1700-1920 (2h 20m)	38 patients in the ED Admits: 1-ICU; 3-4B; 4-Floor ED waiting room: 6 urgent patients
06/27/02	2000-0330 (7h 30m)	35 patients in the ED Admits: 3-4B; 5-Floor ED waiting room: 3 urgent patients
06/28/02	1340-2155 (8h 15m)	37 patients in the ED Admits: 6-Floor ED waiting room: 10 urgent patients
06/29/02	1340-1610 (2h 30m)	31 patients in the ED Admits: 1-4B; 1-Floor ED waiting room: 5 urgent patients

5) FINANCE REPORT – STATEMENT OF REVENUES AND EXPENDITURES

Gregg Sass, Chief Finance Officer, presented the attached report on the Information Systems Project to Replace Out-Sourced Billing Contract, (Attachment A).

Commissioners' Comment

- Commissioner Monfredini inquired how long it would take for SFGH to determine that new financial system would work. Gregg Sass responded that SFGH will be engaged in “parallel runs” in September and October 2002 and would be able to reassess the new system in November-December 2002.

6) UPDATE ON THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH LONG RANGE SERVICE DELIVERY PLANNING PROJECT

Anthony Wagner, Chief Executive Officer of Hospital Systems, provided an update status on the San Francisco Department of Public Health Long Range Service Delivery Planning Project to rebuild San Francisco General Hospital Medical Center. This update was presented to the JCC-CHN last week and will be presented to the Health Commission on July 16, 2002. Mr. Wagner

introduced Lewin and Associates' consultant, Keith Hearle, who presented the update status on the SFGH rebuild (Attachment B).

Commissioners' Comments:

- Commissioner Monfredini suggested changing on Slide 10 "Givens" to "Assumptions"; on Slide 11 "Elder" to "elder."
- Commissioner Monfredini agreed that SFGH should continue with Master Planning in January 2003 even if a decision is not made by UCSF regarding co-location.
- Commissioner Chow asked if co-location is truly realistic given the City's commitment to continuing governance over SFGH and the services that SFGH provides in its facility. In addition, Commissioner Chow raised the issue of 4,000 CCSF employees going to the new facility and UC Regents not likely wanting to have any oversight over this employees.

Members' Comments:

- Chris Wachsmuth clarified that "heliport" differs from "helipad." Helipad feasibility should be included in the presentation, not heliport.
- Commissioner Monfredini invited all JCC-SFGH members to provide feedback about their preference – Mission Bay vs. Potrero site. Many members had concerns about splitting the locations of the behavioral, primary care, and skilled nursing services in the Mission Bay proposal but many also saw the benefits of co-location with UCSF at Mission Bay.

7) PUBLIC COMMENT

None

8) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

None.

B) Vote on Whether to Hold a Closed Session

Action Taken: The Committee voted to hold a closed session.

The Committee went into closed session at 5:55 p.m. Present in closed session were Sue Currin, Myra Garcia, Mozettia Henley, John Kanaley, John Luce, M.D., J. Renee Navarro, M.D., Kathy Murphy, J.D., Gene O'Connell, Roland Pickens, Hiroshi Tokubo, Chris Wachsmuth, Connie Young.

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

APPROVAL OF CLOSED SESSION MINUTES OF JUNE 11, 2002

Action Taken: The Committee approved the closed session minutes of June 11, 2002.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM

CONSIDERATION OF CREDENTIALING MATTERS

Action Taken: The Committee approved the credentials report.

MEDICAL STAFF REPORT

D) Reconvene in Open Session

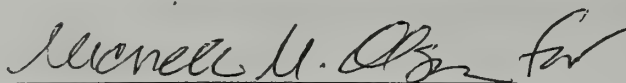
The Committee reconvened in open session at 6:13 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any and all discussions held in closed session.

8) **ADJOURNMENT**

The meeting was adjourned at 6:15 p.m.



Connie Young
Executive Assistant to the CEO, SFGH

Attachments (2)



Community
Health Network
OF SAN FRANCISCO

MEMORANDUM

DATE: July 9, 2002

TO: Lee Ann Monfredini, Commissioner
San Francisco General Hospital Joint Conference Committee

FROM: Gregg Sass, Chief Financial Officer
Community Health Network

SUBJECT: Information Systems Project to Replace Out-Sourced Billing Contract

Summary

SFGH has a longstanding contract with Health Management Systems, Inc (HMS) to provide outsourced billing services for Patient Accounting. We have decided not to renew the contract at expiration on June 30, 2003 and instead bring the billing capability in-house. We expect to accomplish the conversion early in 2003 and therefore the annual budget for SFGH includes additional personnel cost and one time costs related to the technology transfer, much of which will be funded from savings in reduced payments to HMS.

To meet our aggressive timeline we will be seeking approval of a sole source contract with SIEMENS to provide professional services and software products needed to achieve our goal. The contract will be in the \$1,000,000 range and will have a term of 2 years, consistent with the expiration of the SIEMENS Master Agreement in June 2004. We expect to present this contract request to the full Commission on August 20.

Cost Benefit Overview

Current annual cost of the HMS agreement \$1,650,000

Estimated one-time Cost of SIEMENS contract \$1,000,000

Annual recurring operating expenses:

Salary and benefits (8 FTEs)	\$ 760,000
Recurring technology expenses	<u>150,000</u>
Total Recurring	\$ 910,000

Attachment A
Page 1 of 4

Background

The HMS contract has been in existence for more than 10 years. When SFGH first installed the SMS Invision system, a decision was made to fully install only the "front end" modules for Admitting, registration, and charge capture, and outsource the "back end" billing and collection functions. HMS provides full service billing and collection services and is paid 6% of collections not to exceed \$1,650,000 annually. The patient financial services department provides HMS with tapes of patient demographic information and charges. HMS constructs claim forms from the detail provided and submits them electronically to payors. Collections are returned directly to the City. HMS provides electronic remittance advices which we apply to relieve Accounts Receivable.

Problems with the Existing Agreement

Compliance Risk

As billing requirements have become more complex and compliance issues have taken on greater significance, we are assuming increasing risk of non-compliance due to this arrangement. HMS produces and submits claims on our behalf but we remain responsible for consequences of non-compliance. While the HMS service was acceptable in early years, current requirements under Medicare outpatient prospective payment and outpatient FQHC prospective payment have been difficult to accommodate.

Reimbursement Losses

In 1997 and 1998, HMS submitted incomplete FQHC claims that ultimately resulted in over \$1M in lost payments to SFGH and the community clinics. Efforts to recover the lost reimbursement have not been successful and we are in a dispute with HMS that is expected to result in a significant financial settlement.

Financial Status

HMS has reported operating losses in the past several quarters. Shares of HMS stock have fallen from a high of \$38 in 1996 to \$3. This has limited their ability to invest in product development and support. HMS has recently completed a re-structuring that included the sale of business assets. New leadership at HMS appears to be focused on a turnaround in financial performance and there is an expectation of a return to profitable operations in the coming year. They report growth in their top line revenues. Recent performance at SFGH has shown significant improvement compared to previous years. Following is an excerpt from the HMS annual SEC filing:

Divestitures and monetization of non-strategic assets

As a fundamental element of the strategic review the Company completed the following divestitures:

Sale of EDI business. In January 2001 the Company sold its electronic transaction processing ("EDI") business, consisting of substantially all the assets of the Company's wholly owned subsidiary, Quality Medi-Cal Adjudication, Inc., and certain assets of its

wholly owned subsidiary, Health Receivables Management, Inc. The sale price of \$3.0 million resulted in a pre-tax loss of \$0.1 million. This business, which operated in the Provider Revenue Services Group, was a commodity billing service, and the Company determined the service was more appropriately purchased from specialized external vendors.

Sale of CDR business. In July 2001 the Company sold its credit balance audit business through the sale of substantially all the assets of its wholly owned subsidiary, CDR Associates, Inc. The sale price of \$3.2 million resulted in pre-tax gain of \$1.7 million. The business was not core to the technology-based third party liability processing business of the Payor Revenue Services Group, and consequently the Company sought to monetize this non-strategic asset through its sale.

Sale of Health Care microsystems, Inc. ("HCm"). In December 2001 the Company sold its wholly owned subsidiary, Health Care microsystems, Inc. which operated as the Company's Decision Support Group. The sale price of \$9.8 million resulted in a pre-tax gain of \$1.9 million. The Company had originally entered the software business in 1995 through its merger with HCm, a company that furnished microcomputer-based distributed decision support software systems and consulting services, to healthcare providers and payors. The Company determined this business was not critical to the Company's strategy of outsourcing Provider business offices. As this business was a separate reportable segment, representing a separate class of customer and major business, its operating results are presented as discontinued operations for all periods presented.

Closure of Payor Systems Group ("PSG")

In 1995 the Company purchased a 43% equity interest in Health Information Systems Corporation ("HISCo"). Then in 1997 the Company purchased the remaining 57% ownership stake, at which time HISCo merged with its sole operating subsidiary, Health Systems Architects, Inc., and was renamed HSA Managed Care Systems, Inc. ("HSA"). This entity constituted the Company's Payor Systems Group and furnished various information technology based consulting and other services, and software products to managed care organizations. In March 2001 the PSG business received notification from its development partner, canceling their participation in the Company's managed care system development initiative. As a consequence, the Company recognized a restructuring charge of \$5.1 million and an asset impairment charge of \$3.5 million associated with the PSG business. Later in June 2001 the PSG business received a cancellation notice from its largest customer. In light of these events, the Company determined to proceed with an orderly closure of the PSG by accelerating a wind-down of its remaining operations. As this business was a separate reportable segment, representing a separate class of customer and major business, its operating results are presented as discontinued operations for all periods presented.

Restructuring Charges, Asset Impairments, and Other items

In addition to the business divestitures and closure discussed above the Company incurred several other charges in fiscal year 2001 resulting from the strategic review of its business operations, infrastructure, and management team. In particular:

- In April 2001, the Company incurred a restructuring charge of \$0.8 million for facility exit costs and employee severance costs associated with the closure of its Washington, D.C. office.

- Throughout fiscal year 2001 the Company incurred \$1.4 million in compensation costs for severance and retention bonuses that were paid during the year, resulting from its divestiture efforts and headcount reduction efforts.

- In December 2001, the Company incurred a restructuring charge of \$1.8 million consisting of \$1.3 million for facility exit costs associated with a plan to reduce the amount of office space the Company occupies at its headquarters in New York City, and \$0.5 million for severance costs associated with reductions in the information technology and facilities maintenance departments.

- In December 2001, the Company recognized a charge of \$1.3 million for the impairment of its goodwill resulting from the 1997 acquisition of the Global business unit. This impairment charge was based on a

recoverability analysis which had been triggered by the significant underperformance of the unit relative to the expected historical results and the current projections of future operating results. The impairment charge was measured based on the projected discounted future cash flows from the business unit over the remaining fifteen year amortization period of the goodwill using a discount rate reflective of the Company's cost of funds.

At the end of calendar year 2001, the Company has completed its strategic review and is now organized around its two core businesses, the Payor and Provider Services Divisions, with a business plan focused on growing revenues and reaching profitability.

Long Range Service Delivery Program Plan for SFGHMC Rebuild Recommendations and Options

SFGHMC JCC
July 9, 2002

THE LEWIN GROUP

Background

- ◆ In 1996 SB 1953 was passed as amendment to the Alfred E. Alquist Hospital Seismic Safety Act.
- ◆ SB 1953 mandates that all California acute care hospitals meet new seismic safety standards by 2013.
- ◆ Hospitals failing to comply will have to close acute care services after 2008.

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Impact of SB 1953

- ◆ About 80% of California hospitals are impacted by SB 1953.
- ◆ Nearly half of California's 2,700 hospitals must be rebuilt or retrofitted.
- ◆ Necessary seismic upgrades will cost an estimated \$24 billion statewide.
- ◆ Hospitals must find their own means to finance their seismic upgrades and rebuilds.

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First Planning Phase

- ◆ In January 2001, the SF Health Commission approved resolution #1-01 supporting the rebuild of SFGHMC by 2013.
- ◆ A 7-week planning process was initiated to explore feasibility and cost of rebuilding, estimated at \$500 million.
- ◆ This first planning phase focused narrowly on meeting SB 1953 mandate.

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An Opportunity

- ◆ It became evident that SB 1953 represented an unique opportunity to plan and improve the way SFDPH/SFGHMC provides services so that we could best meet the needs of our clients 10--40 years into the future.

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Long Range Service Delivery Plan

- ◆ The second phase of planning--The Long-Range Service Delivery Plan--was initiated to address questions regarding the long term program needs and the future role of SFGHMC.
 - Predict/determine the range and types of services that SFDPH should provide in the future.
 - Determine how to best provide these services (where? how much? with who?).

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Long Range Service Delivery Plan

- ◆ In January 2002, the Lewin Group was hired to assist the SFDPH in making programmatic recommendations.
- ◆ Two planning groups were established to help guide this process:
 - 1) Internal--SFDPH & UCSF clinicians and administrators
 - 2) Community--45 members: patients, community groups, neighbors, politicians, labor, activists, health care professionals and consultants.

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Planning Principles

- ◆ Recommendations are based on principles for:
 - Improving access to care
 - Improving quality of care
 - Best practices
 - Cost efficiency and financial stability
 - Future needs
 - SFDPH Strategic Goals
 - Meeting SB1953 requirements

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Planning Principles

- ◆ Recommendations by Lewin were made from:
 - Data analysis and projections
 - 50 interviews with community experts
 - Input from planning groups
 - Survey of national best practices and models
 - Consultants expertise

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Assumptions

Widely accepted assumptions that emerged from prior rebuild or strategic planning:

1. Social problems will persist
2. DPH will maintain its core mission/role
 - Safety net provider
 - Level I Trauma
3. DPH will continue to ensure a full continuum of services (physical, behavioral, social)
4. DPH will continue its affiliation with UCSF
5. The City and the Department has limited resources
6. Rebuild SFGHMC

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Open Questions

Critical issues that require additional decisions

- ◆ **Co-location with UCSF:** Partnerships/Collaboration with UCSF at Mission Bay
- ◆ **Trauma:** Level I importance to SF, implications of regionalization and heliport
- ◆ **Psychiatry:** implications of locating inpatient services at a different site than acute medical services, status of services at other SF hospitals, unmet needs, and community alternatives
- ◆ **Ambulatory Care:** community versus hospital-based care
- ◆ **Pediatrics:** whether or not to continue inpatient services at SFGHMC or partner with others
- ◆ **Obstetrics:** whether or not to continue inpatient services at SFGHMC or partner with others
- ◆ **Elder Care:** whether or not to pursue a strategy to retain elder patients

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SFGHMC should continue exploring collocating with UCSF at Mission Bay

Site Options:

1. Collocation with UCSF at Mission Bay

if agreement is not reached by January 2003 then,

2. SFGHMC should be rebuilt at the current Potrero Avenue campus

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Estimated Distance and Travel Time:
 St. Louis to SFGHMC: 13 miles/24 minutes
 SFGHMC to Mission Bay: 2.1 miles/6-8 minutes

Community Based Primary Care Centers
 298,000 visits

Mission Bay Campus

- Acute Med/Surg beds
- ED and Trauma/ICU
- Ambulatory Care
- ~60,000 high end Specialty Care
- Behavioral Health
- ~50 Med/Psych beds
- ~400 beds?
- Full Health acute beds

Peters Campus

- Ambulatory Care
- Urgent Care
- ~60,000 Primary Care
- ~60,000 Specialty Care
- SNF - 50 beds (may be at L111)
- Behavioral Health
- acute beds ??
- MH/RF
- PES
- Other

0 1 2 3 4 5 6 7 8 9 10 miles

California

13

Benefits

- Unprecedented opportunity to ensure continued partnership with UCSF
- Extension of 100-year relationship
- Enhances quality of care
 - Low-volume services, specialty care, and expertise
- Lower project cost
- Lower operating cost
 - shared medical technology
 - shared ancillary services
- Coordinated GME & research programs
- Creates additional financing options
- Greater public support?
 - Ensures access and availability to sub-specialists at UCSF
 - Construction not as disruptive to patient care
 - Creates Potrero campus opportunities for SFDPH

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Challenges

- SFGHMC/UCSF viewed as having compatible, but different missions
- May not be able to include all SFGHMC services in co-located site
- UCSF is exploring 14 rebuild options, and has a different timeline. UCSF commitment needed by Jan 2003 for SFDPH to meet S.B. 1953 deadlines
- Potentially lengthy negotiations: adds uncertainty
- Two tiers of care?
- Coordinated decision-making required
- Land availability and cost
- Implications of SFDPH operating two campuses
 - Psych and ambulatory care programs

1

1

Community Based Primary Care Centers

- 290,000 visits

Paterson Campus

- Acute Med/Surg beds
- Emergency Room and Trauma/ICU
- Ambulatory Care
- Urgent Care
- 60,000 Primary Care
- 190,000 Specialty Care
- 50% - 30 beds (may be as little)
- Behavioral Health
- Acute beds
- 30 Med/Psych beds
- MH/IF
- PLS
- 200 Health acute beds

1

Benefits

- CCSF/SFDPH own the land
- All SFGHMC services located on the same campus /not operating at an additional campus
- Continue ties to Potrero Avenue neighborhood

Challenges

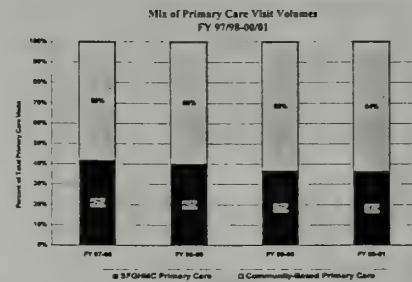
- Neighborhood concerns:
 - Helipad
 - Impact of rebuild
- Benefits of UCSF collocation less likely
 - Access to sub-specialty care and higher technological equipment and services
 - Cost
- Greater impact of rebuild on patient care during construction

1

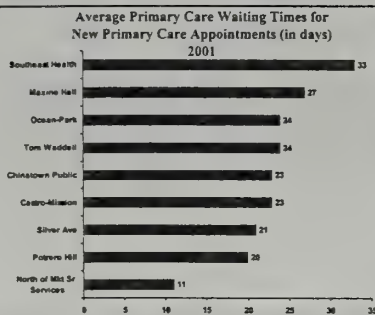
Ambulatory Care

- ◆ SFDPH should move some hospital based ambulatory care services to the community (30-40,000 visits) and expand services (20,000 visits).
- ◆ SFDPH should explore the feasibility of including financing this as part of the bond measure or through other financing.
- ◆ Organize ambulatory care at the SFGHMC campus as a "Super Clinic."

Ambulatory Care: The mix of SFGHMC and community primary care clinic volume already has been changing.



But community primary care clinics are constrained, suggesting a need for additional capacity.



Patient satisfaction with community primary care clinics is somewhat higher than with SFGHMC primary care sites.

- ◆ "Excellent/very good" overall satisfaction scores:
 - 79.7 percent for CHN primary care clinics that could be expanded
 - 70.0 percent for SFGHMC clinics
- ◆ Possible reasons:
 - Location / proximity
 - Consistency of provider
 - Continuity of care
 - Perceived safer and more accessible environment
- ◆ However, patients selecting SFGHMC primary care recognize the benefits of "one-stop shopping" and access to specialists

Ambulatory Care: Shift 30-40,000 lower acuity ambulatory care visits from SFGHMC to community. Increase overall ambulatory visits by 5% to account for projected growth.

- | Benefits | Challenges |
|---|---|
| ◆ Provides care closer to home, improving access | ◆ Current sites capacity constrained; requires new capital investment in renovation or new site selection |
| ◆ Contributes to improved patient satisfaction | ◆ Requires funding |
| ◆ Will improve long waiting times | ◆ Requires addressing medical staff/teaching issues in off-campus sites |
| ◆ Meets SFDPH goal to move care into the community | ◆ Some patients may prefer hospital-based care |
| ◆ Strategy of other public health care systems (New York, Dallas) | |

Organize Ambulatory Care as a "Super Clinic" at Potrero Avenue site

- | Benefits | Challenges |
|--|--|
| ◆ Integrated, "one stop shopping" model is a progressive approach preferred by patients: | ◆ Facilities options need to be developed <ul style="list-style-type: none"> ➢ New building ➢ Existing space |
| ◆ Supports "Center for Vulnerable Populations" | ◆ Higher project cost |
| ◆ Supports ACRC planning | ◆ Community support for larger bond measure or alternative funding sources |
| ◆ Moves services from red brick building | |

Expand Level I Trauma Services by regionalizing and developing medical air transport capability

Benefits

This decision has already been endorsed by the Health Commission

- Level I trauma services ensures:
 - high quality care and access to specialized care
 - public health and safety
 - positively impact the hospital's payer mix
- Supporting trauma also supports SFGHMC as a foremost public hospital in the United States.

Expand Level I Trauma Services by regionalizing and developing medical air transport

Benefits

- Regionalization and development of a helipad would bring additional patients and ensure that Level I Trauma remains viable at SFGHMC
 - Successful expansion unlikely without medical air transport capability
 - San Francisco is one of the few large metropolitan cities without medical air transport
 - timely access if roads or bridges are not available

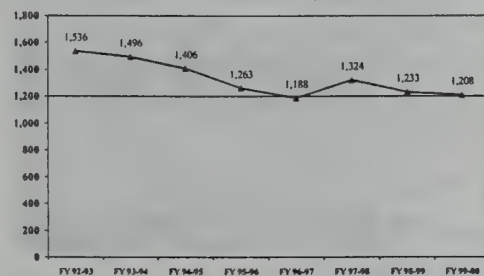
Expand Level I Trauma Services by regionalizing and developing medical air transport

Challenges

- Volume growth is important to continuing to meet Level I Trauma requirements
- Level I Trauma Centers are required to:
 - have at least 1,200 admissions
 - OR 240 admissions with injury severity score > 15
 - Or an average of 35 patients of ISS > 15 for trauma panel surgeons
- SFGHMC trauma volume has declined and just meets the threshold requirement (1,208 admission in FY 2000)
- No other SF hospital has plans to become a Level I Trauma Center, the risk of not expanding could mean that SF no longer can support Level I

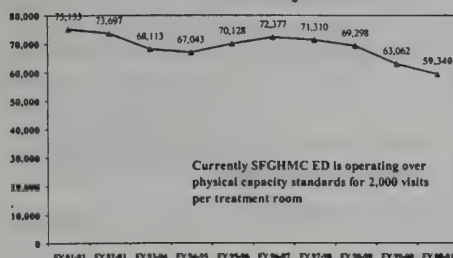
SFGHMC's inpatient trauma volume has declined and just meets the threshold requirement

SFGHMC Trauma Discharges 1993 - 2000
(21% decline over 8 years)



Expand Emergency Dept. physical capacity

SFGHMC Emergency Department Visits
FY 1992 through 2001



Expand Emergency Dept. physical capacity

Benefits

- Allows SFGHMC to conform to current standard of 2,000 visits per treatment station (now operating at ~3,000)
- Lower diversion rates (though this results primarily lack of beds)

Challenges

- Operating and capital cost implications

SFDPH should not include SNF capacity in new hospital construction

Benefits

- Including SNF beds in new construction would be expensive
- It should be possible to accommodate this service at LHH or in old SFGHMC space
 - Currently 5 patients (17%) per month are transferred to LHH
 - LHH new emphasis on community reintegration should facilitate higher numbers of patient transfers
 - LHH rebuild will increase available bed capacity

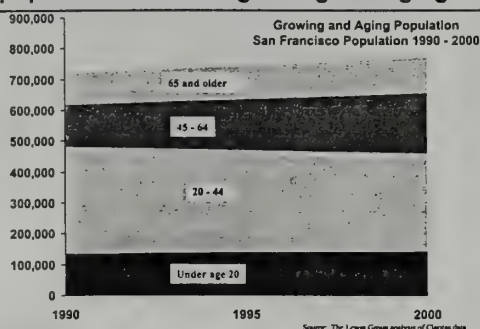
Challenges

- Proximity to acute surgical/medical beds facilitates patient flow
- SNF beds also reduce administrative (disallowed) days

Few general acute care county hospitals in California maintain SNF units

- County hospitals with SNF units (4)
 - Los Angeles County High Desert Hospital
 - Natividad Medical Center
 - San Francisco General Hospital
 - Tuolumne General Hospital
- County hospitals without SNF units (11)
 - Alameda County Medical Center – Highland Campus
 - Contra Costa Regional Medical Center
 - The 4 other LA County Hospitals
 - Riverside County Medical Center
 - San Bernardino County Medical Center
 - San Luis Obispo General Hospital
 - Santa Clara Valley Medical Center
 - Ventura County Medical Center

Like other parts of the U.S., San Francisco's population has been growing and aging



SFDPH pursue a strategy to retain its elder population

Benefits

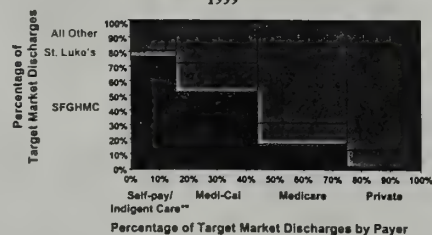
- Meets needs of aging SFDPH clients, including those at LHH (continuity of care)
- Positive financial impacts (e.g., support for medical education, Medicare)
- Poor elderly likely to have greater needs and reduced resources
- Serving needs of patients with complex psycho-social needs is SFDPH center of excellence

Challenges

- Assuring that needs of SFDPH "core populations" (those without options,) are met first
- Program development needed
- Implications for facility design and cost
- Without "champions", success is uncertain

The elder patient population will increase the SFDPH's share of Medicare patients

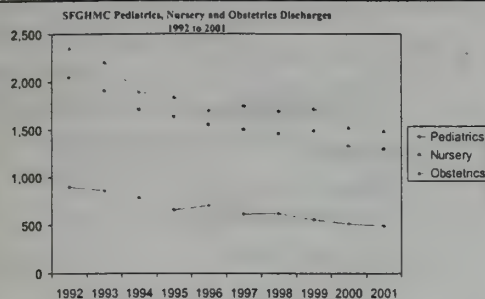
SFGHMC Market Share by Payer
Target Market* Discharges
1999



Other public hospitals have successfully implemented strategies to serve these patients.

Public Hospital	Strategy	Initiatives
Parkland Health and Hospital System	Develop Centers of Excellence around services utilized by the Medicare population	<ul style="list-style-type: none"> • Geriatric Case Management Program – Designed to provide case management and discharge planning services to inpatient, outpatient and emergency room patients 60 years and older • Acute Stroke Unit – Clinicians apply state-of-the-art treatment procedures to prevent widespread tissue damage in acute stroke victims • Arrhythmia Management Center – Evaluates and treats patients with heart rhythm disturbances
Provident Hospital	Actively market to seniors	<ul style="list-style-type: none"> • Conducts large senior-focused health fairs annually • Hosts senior wellness center clubs • Reaches out to the middle-aged children of seniors who are frequently the healthcare decision-maker for their parents • Provident provides targeted mailings, promotional seminars and lunches
Cambridge Health Alliance and Parkland Health and Hospital System	Ensure that services are "senior-friendly"	<ul style="list-style-type: none"> • Cambridge and Parkland's Advanced Access program allows older patients to obtain same or next day clinic appointments

SFDPH should consolidate inpatient pediatrics and obstetric services with UCSF

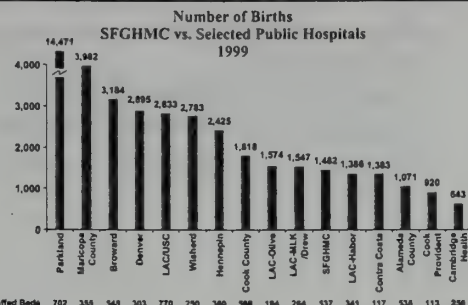


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Source: CUN Planning

37

SFGHMC performs fewer deliveries than other public hospitals of comparable size.



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Source: National Association of Public Hospitals

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Consolidate obstetrics with UCSF

Benefits

- Consolidated program would have higher volume (1,300 deliveries at SFGHMC, 1,700 at UCSF)
- Research shows that quality improves with higher program volume
- Births projected to decline further
- Improved access to UCSF specialists and neonatologists

Challenges

- Requires carefully crafted partnership agreement
- Ensuring continuation of unique SFGHMC competencies
- Maintaining midwifery program
- Potential loss of Medi-Cal reimbursement
- Community concern about not providing inpatient maternity care

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Consolidate inpatient pediatrics with UCSF

Benefits

- Children and adolescents are better served in a dedicated facility providing specialized care
- Some complicated cases already referred to UCSF
- Current low census (ADC=4)
- Would reduce problems in maintaining specialized staffing

Challenges

- Requires carefully crafted partnership agreement to assure continued access for SFDPH patients
- Ensuring continuation of unique SFGHMC competencies (drug exposed, abused, foster care,)
- Impact on pediatric trauma

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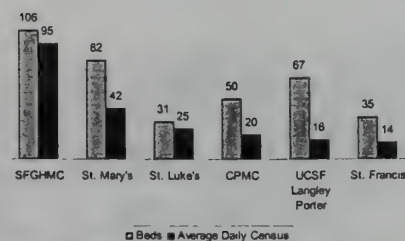
Behavioral Health Options

- Maintain current number of psych acute beds
- Include a 30-bed comprehensive medical-psychiatric inpatient unit in new hospital construction
- Continue exploring feasibility options for psych in the Mission Bay for:
 - Moving psych acute along with hospital to Mission Bay
 - Maintaining psych acute at separate Potrero campus

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With risks to inpatient programs at other hospitals and forces contributing to higher demand, SFGHMC should maintain the current number of inpatient psychiatric beds.



Source: Fiscal Year 1999 OSHPD Disclosure Report Filings.

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SFDPH should include a 30 bed comprehensive medical-psychiatric inpatient unit in new hospital construction.

SFGHMC and DPH clients have a high level of psychiatric and medical "co-morbidities."

- Studies show that 40% (acute care) - 80% (high user patients) have complex physical, mental and substance abuse problems.
- Laguna Honda Hospital: 70% percent have physical, mental and substance abuse problems.
- CHN Patients: 11% utilize CHMS services and 10% use substance abuse services

Other data confirm a high number of dually-diagnosed patients.

	Patients	Discharges
Medical / surgical patients		
Total	11,514	14,630
Admissions to psychiatry	288	422
Behavioral diagnoses (top 52)	859	993
Psychiatry patients		
Total	1,733	2,444
Admissions to medical / surgical	291	458
Medical / surgical diagnoses (top 52)	606	715
"Med-Psych" patient admissions	579	880
Dually-diagnosed patients	1,465	1,708

SFDPH should explore moving acute psych to Mission Bay

Benefits

- ◆ Continued integration of hospital-based psychiatric care for SFGHMC
- ◆ Psychiatry not "left behind"
- ◆ Coordination of PES & ER

Challenges

- ◆ Project cost
- ◆ Implications for land need
- ◆ Maintaining services for MHRF clients
- ◆ Integrating psychiatric care into ambulatory services provided at the Potrero Avenue site

SFDPH should maintain psych acute at Potrero campus even if SFGHMC moves

Benefits

- ◆ Opportunity to have comprehensive continuum of Behavioral Health service at one site
- ◆ Maintain coordination with MHRF
- ◆ Facilitates development of "Center for Vulnerable Studies"
- ◆ Facilitates integrating behavioral health services with primary care at the Potrero site

Challenges

- ◆ Assuring medical presence for medically complex behavioral health clients
- ◆ Coordinating care at two sites
 - PES & ER services
 - Med/psych patients
 - Diagnostics
- ◆ Psychiatry "left behind", increased stigma for psychiatric patients
- ◆ Risks regarding future resource commitments to the Behavioral Health programs at Potrero Avenue campus

What is your vision?



Rebuild Timeline

July 16, 2002	Recommendations presented to Health Commission for approval
July 2002-03	IMP/SFGHMC Rebuild Facility Planning groups meet
January 2003	IMP/Facility Plan presented to Health Commission for approval
2002-03	Plan presented to the Mayor, Supervisors, City Depts, community.
Nov 2003	Election bond measure
2013	Completion of the SFGHMC Rebuild

Rebuild Next Steps

- Institutional Master Plan
- Finance Plan
- Program Planning Implementation
- Continued Discussion with UCSF
- Community Education

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

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cellah

Edward A. Chow, M.D.
President

Roma P. Guy, M.S.W.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

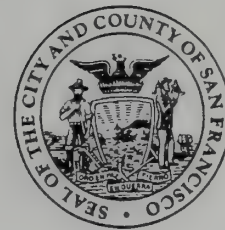
Harrison Parker, Sr., D.D.S.
Commissioner

David J. Sánchez, Jr., Ph.D.
Commissioner

John I. Umekubo, M.D.
Commissioner

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Willie L. Brown, Jr., Mayor
Department of Public Health



Mitchell H. Katz, M.D.
Director of Health

Michele M. Olson
Executive Secretary

Tel. (415) 554-2666
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CANCELLATION NOTICE

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JOINT CONFERENCE COMMITTEE
FOR THE
SAN FRANCISCO GENERAL HOSPITAL
COMMITTEE MEETING

The Joint Conference Committee for the San Francisco General Hospital meeting, scheduled for Tuesday, August 13, 2002 has been cancelled.

The next regularly scheduled meeting will be Tuesday, September 10, 2002 from 3:45 to 5:30 p.m. at the Hospital's Conference Room #2A6, as usual. An agenda will follow.

For information call the Commission Office at 554-2666.

(Posted July 29, 2002)

Edward A. Chow, M.D.
President

Roma P. Guy, M.S.W.
Vice President

Arthur M. Jackson
Commissioner

Lee Ann Monfredini
Commissioner

Harrison Parker, Sr., D.D.S.
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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, September 10, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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Commissioner Lee Ann Monfredini, Chair
Commissioner John I. Umekubo, M.D.

09-09-02 A1332 1070

- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF JULY 9, 2002
**Minutes of July 9, 2002*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGHMC)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Officer)
**Report*
- 5) PUBLIC COMMENT**

6) CLOSED SESSION

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: APPROVAL OF CLOSED SESSION MINUTES OF JULY 9, 2002

FOR DISCUSSION: CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: CONSIDERATION OF CREDENTIALING MATTERS
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION AND POSSIBLE ACTION: MEDICAL STAFF REPORT
J. Renee Navarro, M.D., Chief of Staff

D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

7) ADJOURNMENT

- * Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.
- ** Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: **www.sfgov.org/ethics**.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: **Donna_Hall@ci.sf.ca.us**.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: **www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm**

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Edward A. Chow, M.D.
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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, September 10, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

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1) CALL TO ORDER

The meeting was called to order by Commissioner John Umekubo at 4:00 p.m.

Present: Commissioner John I. Umekubo, M.D.

Absent: Commissioner Lee Ann Monfredini, Chair

Staff: Anne Chang, Wahid Choudhury, Sue Currin, Myra Garcia, Mozettia Henley, Seth Ingram, Valerie Inouye, John Kanaley, Talmadge King, M.D., Beth Maloney, Alison Moed, Renee Navarro, M.D., Gene O'Connell, Roland Pickens, Gregg Sass, Cathryn Thurow and Hiro Tokubo

2) APPROVAL OF MINUTES OF JULY 9, 2002

Action Taken: The Committee approved the minutes of the July 9, 2002 San Francisco General Hospital Joint Conference Committee.

3) HOSPITAL HEALTHCARE UPDATE

Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center, presented the Hospital Healthcare Update.

State Appropriation for Trauma Care

On Thursday, September 5, Governor Davis signed the 2002-03 budget that approved an appropriation of \$20 million for trauma care. This is a reduction of \$5 million from the initial amount contained in the bill passed by the Legislature last weekend.

These much needed funds will help to augment SFGH's contract with UCSF for services that support trauma care. Last year, SFGH received over \$900,000 through a similar bill that provided funds based on trauma cases seen.

UCSF Renal Center – Outpatient Dialysis Services Maintained

After extensive review and careful consideration, SFGH and the San Francisco Department of Public Health have agreed to apply to have the UCSF Renal Center licensed under SFGH. This will ensure that patients can continue to receive chronic outpatient hemodialysis services at the hospital. A management contract between UCSF Department of Medicine and SFGH will be developed to ensure effective management of the unit and minimize disruption to patient care during the transition.

In-patient dialysis services will continue to be provided under the existing SFGH-UCSF Affiliation Agreement.

Containing Outpatient Prescription Costs

Concern about rising costs of pharmaceuticals and providing outpatient prescription services to indigent CHN patients through the current PBM system have caused the Department to investigate recent legislation allowing Federally Qualified Health Centers (FQHC's) and FQHC look-alikes to own drugs in the absence of an on-site pharmacy. This legislation permits clinics to contract with a single pharmacy to dispense drugs legally owned and purchased by the clinic at Federally discounted prices. The Department believes the potential of such an arrangement to contain pharmaceutical costs can be significant, and is preferable to either limiting the drug formulary or more severely restricting access to prescription services. Details on how to implement this type of arrangement still need to be addressed; the Commission will be kept apprised of the Department's progress.

Geriatrics Initiative

SFGH has begun an initiative to improve care to geriatric patients through multidisciplinary teams and provide continuing education to providers. A committee has been established and met with leadership from the SF Veterans Hospital's Geriatrics Program. They include Dr. Seth Landefeld, Dr. Bree Johnston, and Dr. Joan Wood, who expressed great interest in collaborating with SFGH. Given limited resources, they recommended working with the SFGH Inpatient Medicine consult service to create a half-day a week Geriatric Consult Service that involves VA Geriatric Fellows, the Medicine Consult Resident, and a Geriatrics/Medicine Attending. Future directions include developing seminars offered to outpatient settings, exploring the creation of a Medical Director position with a geriatrics background, and working with inpatient pharmacy to optimize patient education and concerns around poly-pharmacy. The committee also hopes to expand geriatric services capacity by developing an outpatient consult clinic, an inpatient palliative care team, and research collaborations with Department of General Internal Medicine providers.

Avon Fundraiser: "Kiss Goodbye to Breast Cancer" Concert – September 23, NYC

The Executive Administrator of SFGH will be attending Avon's fundraiser and awards ceremony being held in New York City on 9/23 to present information on the building of the Avon Foundation Comprehensive Breast Center. Kathleen Kane, Vice-Chancellor of the UCSF Regents, was also

invited by Avon to attend. Attendants from Avon include its CEO, members of their corporate board, and the president of the Avon Foundation and its board.

Security Update

John Kanaley gave an update on the security at SFGH (Attachment A).

Commissioners' Comments

- Commissioner Umekubo asked what financial impact the decision to put the Renal Center on SFGH's license would have on the hospital. Ms. O'Connell said that it is still too soon to say. They may be able to cover the costs with the decreased pharmaceutical costs or other mechanism but it is still premature. Commissioner Umekubo asked the timeline and process for the change in outpatient pharmacy. Ms. O'Connell said that they would like to have a RFP done by April. They would rather pursue this arrangement than limit the formulary, which is the only other way to reduce costs. Ms. O'Connell said the change may be rolled out clinic by clinic, rather than at one time. Commissioner Umekubo asked for a more detailed presentation at a future SFGH Joint Conference Committee meeting. Commissioner Umekubo asked what protocol is followed if there is a violent patient. Mr. Kanaley said that the security backs up the medical staff. However, the calls or response times have not been tracked. Ms. Currin said that from a staff perspective response could be quicker. Commissioner Umekubo asked if the security initiatives described by Mr. Kanaley are built into the budget. Mr. Kanaley responded that all but two have been funded. Funding requests have been made for the Labor and Deliver security and infant security systems. Commissioner Umekubo ask if Mr. Kanaley was satisfied with the hospital's security. Mr. Kanaley responded that he is comfortable that the hospital is taking the right steps. It is a two to three year process.

4) PATIENT CARE REPORT

Sue Currin, RN, Chief Nursing Officer, presented the Patient Care Report (Attachment B).

Commissioners' Comments

- Commissioner Umekubo asked if staff knew the cause of the increased assaults on staff. Ms. Currin said that there has been some shift in the patient population, the length of stay in acute psychiatry is shorter, and more patients are coming into the unit directly from the jails. New medication is less sedating, and this is being researched to determine if this has any affect on the increased violence. Ms. Currin pointed out that assaults are also increasing on the Med-Surg. unit. Ms. O'Connell said the data does not show a connection between assaults and anything that is being done with patient flow. The trend is the dual-diagnosed patients. Commissioner Umekubo requested periodic progress reports.

5) PUBLIC COMMENT

None.

6) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

None.

B) Vote on Whether to Hold a Closed Session

Action Taken: The Committee voted to hold a closed session.

The Committee went into closed session at 5:00 p.m. Present in closed session were the same people in open session except for Wahid Choudhury, Valerie Inouye and Gregg Sass.

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

APPROVAL OF CLOSED SESSION MINUTES OF JULY 9, 2002

Action Taken: The Committee approved the July 9, 2002 closed session minutes.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

CONSIDERATION OF CREDENTIALING MATTERS

Action Taken: The Committee approved the Credentials Report.

MEDICAL STAFF REPORT

D) Reconvene in Open Session

The Committee reconvened in open session at 6:02 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in closed session.

7) ADJOURNMENT

The meeting was adjourned at 6:03 p.m.



Michele M. Olson
Executive Secretary to the
Health Commission

Attachments (2)

Report to the SFGH JCC: SECURITY AT SFGHMC

September 10, 2002

In an effort to keep the Health Commission apprised of the operations within San Francisco General Hospital Medical Center (SFGHMC), this report will give a brief update of security at the Medical Center and show programmed improvements in place or underway. A heightened sense of security has been at the forefront of the Medical Center over the past two years, particularly following the 9/11 events in New York City, Washington DC and Pennsylvania. The perceived needs for security by staff have significantly risen, putting more demands on the Medical Center for security improvements. This report will address many of the programs in place and improvements being made.

- Crime Statistics

- *ATTACHMENT 1* shows the FBI Crime Index of Offenses at the Medical Center from 1998 to 2001. It is apparent that crime at the Medical Center has decreased in the years 2000 and 2001 over the 1998 and 1999 trends. Year-to-date trends for 2002 (not provided) show a decrease in overall crimes by approximately 15 – 20%.
- *ATTACHMENT 2* provides of FBI crime statistics for the Mission District in which SFGHMC is located.

- Security Management

- SFGHMC employs an Institutional Police Department (IP) with a budget of 47.8 FTE to provide total security to the Medical Center. The Medical Center has in place a Security Management Plan that outlines the roles and responsibilities of the Department, the high-risk security areas, and the methods of deterring and responding to crime.

As part of the Security Management Program, the Department identifies performance indicators and reports on these indicators quarterly to the EOC/Safety Committee.

ATTACHMENT 3 shows performance indicator reporting for calendar year 2002. These indicators role up to the FBI Crime Statistics.

- Management Response Team – During the mid-1990's, with the passing of the violence in the workplace standard by CAL/OSHA and the Assembly Bill 508 which focused on threat management, training and heightened security for the Emergency Department (ED), DPH developed a Management Response Team. In turn, SFGHMC developed and maintains it's own Management Response Team. This Team's responsibility is to provide immediate support and follow up for any violence in the workplace incidents: from grief counseling, to Human Resources intervention, to assisting with restraining orders and looking at prevention.
- Security Management Response Team – SMRT – In mid-2001, the Security Management Team merged with the Management Response Team to oversee the campus-wide security issues. With the influence of this committee, a security assessment was conducted and areas of priority concerns have been identified. The "SMRT" conveyed to the EOC/Safety Committee that it's primary focus for improvement in FY03 should be security. The EOC/Safety Committee has adopted security as it's #1 goal for FY03. The Security

Management Response Teams also developed and implemented a Violence in the Workplace Policy specific to SFGHMC. The policy was adopted in August 2002.

- San Francisco Sheriff's Department (SFSD) oversight of the DPH Institutional Police – In October, 2001, DPH and the SFSD entered into a memorandum of understanding as a pilot to determine if a transition of DPH IP to SFSD was a good value to both organizations. The pilot has proven to be a positive improvement to the DPH IP and the final stages of a permanent transition are in progress. Progress at SFGHMC includes improvements in leadership, training, morale, security management, a reduction in crime statistics, a security assessment and a minimum-staffing plan. The merger will be a positive enhancement to SFGHMC.
- Infant Security Task Force – An ongoing subcommittee is in place looking at continual improvements to the infant security issues. A Medical Center-wide "Code Pink" response plan is in place. The Well Baby and Intensive Care Nurseries are under a Secure Lock program. Continued focus of the group is now on infant alarm systems and locking down the Labor and Delivery Unit.
- Security Assessment – In February 2002, a SFGHMC Security Assessment was conducted by the SFSD. The purpose of the assessment was to determine where the vulnerabilities are and improvements needed.
 - Key Outcomes of Assessment
 - Mutual Ownership – Shared responsibilities with staff. Staff needs to take ownership and be involved in the Medical Center's security management.
 - ED – Presence and control of hostile and abusive patients
 - Adequate security staffing
 - More secure triage area
 - Staffing Levels – To budget for and staff with trained professionals. SFGHMC has been running short-staffed costing 500 hours per pay period in overtime. This causes burnout and shortage of staff.
 - Security Systems Improvements
 - Card reader system
 - Centralized alarm
 - Centralized monitoring and dispatch center
 - Improved CCTV systems
 - Lighting
 - Training – Officers need time and resources for training
 - Security Policies and Procedures / Operationalizing

- Security Improvements
 - Increased staffing at main and lobby entrances 09/11/02
 - SFSD oversight of DPH Institutional Police Department
 - Mutual ownership of security
 - New security orientation has been implemented
 - ED Security
 - As SFSD transition is implemented, staffing will be maintained to fill two positions more consistently
 - ED Triage area is being reconfigured with construction funds to make the area more secure
 - Staffing levels –under the SFSD MOU, an agreed upon staffing level will be maintained. Complete transition expected by January 2003.
 - Security Systems Improvements (refer to schedule *ATTACHMENT 4*)
 - Cardkey – swipe badge system for the campus – see schedule
 - Basement Tunnel Security – Securing access to the hospital via. the tunnel systems – see schedule
 - Central Alarm – Entrance / upgrade all panic alarm systems – see schedule
 - CCTV Upgrades – Non-capital dollar improvements that will be implemented over 2 – 3 years
 - Centralized Dispatch – Initial funding allocated FY03 – see schedule
 - ED Triage area construction – see schedule
 - MHRF personal alarm system – see schedule
 - Infant Security
 - Lock down of Labor and Delivery – requesting funding
 - Infant security system – requesting funding



FBI Crime Index Offenses, 1998-2001
SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER

VIOLENT CRIME:	1998	1999	2000	2001
Homicide/Manslaughter	0	0	0	0
Rape:				
Rape by Force	2	2	1	3
Attempt to commit rape	0	1	0	0
Robbery	4	5	4	0
Aggravated Assault	13	7	5	6
TOTAL VIOLENT CRIME	19	15	10	9
 PROPERTY CRIME:				
Burglary	10	16	5	16
Larceny-Theft:				
Bicycle Theft	16	4	8	3
Other Larceny-Theft	228	233	162	192
Motor Vehicle Theft	7	8	4	6
Arson	2	1	4	1
TOTAL PROPERTY CRIME	262	262	183	218
TOTAL FBI CRIME INDEX	282	277	193	227

Other Offenses, 1998-2001
SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER

OTHER OFFENSES	1998	1999	2000	2001
Simple Assault	87	81	88	75
Sex Offense-Indecent Exposure	2	1	2	1
Sex Offense-All Others	3	2	5	2
Weapons-Firearms	2	1	0	0
Weapons-All Others	3	2	1	2
Bomb-Actual	0	0	0	0
Bomb-Threat	2	1	0	2
Disturbing the Peace	14	13	13	13
Trespassing	36	30	40	40
Vandalism	19	25	13	34
Forgery/Fraud	0	9	2	4
Narcotics-Felony	22	15	14	21
Narcotics-Misdemeanor	4	1	4	6
Public Drunkenness	13	15	17	9
Vehicle Code-Hit & Run	4	14	8	2
Vehicle Code-All Others	1	0	1	0
Warrants Served-Traffic/Others	76	60	60	60
Miscellaneous Offense Reports	77	58	60	47
TOTAL OTHER OFFENSES	365	328	328	318

Statistics based on Department of Justice-Uniform Crime Reporting

Mission District

PART-I CRIMES	THIS PERIOD			YEAR-TO-DATE		
	DEC-00	DEC-01	% Change	YTD 2000	YTD 2001	% Change
Homicide	1	1	.00%	5	9	80.00%
Rape	4	1	- 75.00%	38	28	- 26.31%
Robbery	52	53	1.92%	568	668	17.60%
Aggravated Assault	32	33	3.12%	474	451	- 4.85%
Burglary	67	56	- 16.41%	703	699	- .56%
Other Larceny	147	124	- 15.64%	1,922	2,046	6.45%
Auto Boosting	61	136	122.95%	1,182	1,400	18.44%
Motor Vehicle Theft	67	93	38.80%	755	914	21.05%
Recovered Vehicle	0	0	.00%	8	- 3	- 62.50%
District Total:	431	497	15.31%	5,655	6,218	9.95%

Dist-Plot	Month Y-T-D	Homicide	Rape	Robbery	Aggr Assau	Burg lary	Auto Boost	Other Larcn	Veh Theft	Rcv Veh	PART-I TOTAL
D-448	12/2001	0	0	0	1	1	9	10	1	0	22
	YTD2001	0	3	1	6	15	65	128	12	0	230

SECURITY MANAGEMENT QUARTERLY REPORT

Date Submitted: 09/3/02

Reporting Area/Department: Institutional Police Department
Time/Period Covered: January 1, - December 31, 2002

Report Submitted by: Sgt. Rafael Restauro
Report Prepared by: Sgt. Rafael Restauro

This report includes results of the monitoring of performance indicators which are used to monitor the effectiveness of the Security Management Program and which may identify issues requiring action by the Environment of Care Committee.

Analysis of Performance Indicator Results for Quarterly Reports:

Action Item # (If applicable)	Performance Indicators	Expected Threshold Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	BATTERY By Location: Emergency Department Pes/Psych Units MHRF Seneca Program OPD Lobby SFGHMC Campus Public Street	5	4	2	6	6	1	5	5	15				
			2	0	1	1	0	1	0	0				
			0	0	1	1	0	2	0	9				
			1	0	2	2	0	0	0	2				
			0	0	0	0	0	1	0	1				
	ASSAULT WITH DEADLY WEAPON	1	0	0	0	1	0	1	1	0				
			0	0	1	0	1	0	0	0				
	BRANDISHING DEADLY WEAPON/POSSESSION	1	0	0	1	0	1	0	0	0				
			0	0	0	0	0	0	1	0				
	SEXUAL ASSAULT/BATTERY	1	0	0	0	0	0	0	1	0				
	ASSAULT	1	1	0	1	1	2	0	2	2				
	ROBBERY	1	0	0	0	0	0	0	0	0				
	BURGLARY	1	3	0	0	0	0	2	1	0				
	PETTY THEFT By Location: Building 5 Red Brick Building MHRF SFGHMC Campus Outside SFGHMC CHN Headquarters	7	4	3	2	8	5	12	6	5				
			3	1	2	5	3	6	4	5				
			0	0	0	1	0	5	2	0				
			0	1	0	2	2	0	0	0				
			1	1	0	0	0	0	0	0				

Action Item # (If applicable)	Performance Indicators	Expected Threshold Level	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	GRAND THEFT By Location: Building 5 Red Brick Building MHRF CHN Headquarters Public Street Bicycle Rack IFO Main Lobby Parking Lots	3	2	2	2	1	0	3	2	2				
	FIRE/ARSON	1	0	0	0	1	1	0	0	0				
	SUICIDE/ATTEMPTED	1	1	0	1	0	0	0	2	1				
	AIDED CASE/INJURY	1	0	1	0	2	1	1	0	0				
	UNUSUAL OCCURRENCE	1	0	0	0	0	0	1	0	0				
	AUTO ACCIDENT/H&R /Injury /City Vehicle /Others	2	1	0	2	0	0	0	2	1				
	AUTO BOOST By Location: Garage SFGHMC Campus Surrounding Public Streets -1100 Block Vermont Street	3	7	3	7	7	7	3	4	3				
	AUTO STOLEN/ATTEMPTED	1	0	0	0	1	0	1	1	0				
	AUTO RECOVERED	1	0	0	0	0	0	0	0	0				
	AUTO VANDALISM	1	0	1	2	0	1	2	1	1				

2003

2002

Attachment
Page 8 of 8

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 9/10/02

Sue Currin, RN, MS, Chief Nursing Office

1. Nurse Retention & Recruitment

The current overall vacancy rate for SFGH Nursing Services is 11% (140 FTEs), with 9% for RNs (56 FTEs) and 13% for LVNs/LPTs (27 FTEs). The highest vacancy rates remain in the 4B Stepdown Unit at 29% and acute psychiatry units ranging from 8 to 17%.

The Emergency and Critical Care Training Programs are scheduled to begin in 10/02. The current vacancy rates in these two areas are 6% and 11% respectively.

Nursing Workforce Initiative: SFGH has collaborated with the San Francisco Private Industry Council, the San Mateo Workforce Investment Board and 12 other hospitals in a grant application for the Nursing Workforce Initiative. Announcement of the \$1.5 million awards will be made this Friday. The primary purpose of the grant is to recruit, train and retain nurses to meet California's current and long term need for nursing care. The San Francisco/San Mateo grant will increase LVN and RN enrollment at SF City College and College of San Mateo, increase enrollment in the CCSF LVN Refresher Course for foreign trained nurses, and provide funds for nursing prerequisite courses for hospital workers. In anticipation of the grant award, an educational survey is currently being conducted at SFGH.

LVN/LPT Scholarships: Nursing Services will offer a reduced workweek to two LVN/LPTs who are currently enrolled in RN school beginning January 2003. The Nursing Scholarship Committee, a subcommittee of the Nursing Retention and Recruitment Committee will develop and implement a process to select two individuals for the reduced work week program, modeled on the criteria of the former DPH 20/20 program. These individuals will attend school 20 hours per week while receiving full time pay. Staff nurse and labor unions are participating on the Scholarship Committee.

2. Staff Assaults in Acute Psychiatry

The acute psychiatry inpatient units at San Francisco General Hospital have experienced an increase in the number of physical assaults upon our staff. There have been 42 staff assaults since 1/1/02. The number of assaults on the day, evening and night shifts were 21, 14, and 6 respectively. Thirteen staff lost a total of 56 workdays because of the incidents. The average number of lost workdays was 4 and the median was 2. The difference between the average and median is due to one staff who lost 23 days.

The Psychiatry Department has taken many important steps to reduce the incidence and severity of assault over the last 2 years. These activities have included training, education, specialized consultation, modifications of the physical environment, and post-

assault counseling (see Attachment #1). In an effort to maintain the safest possible environment, administrative and clinical staff have developed an action plan to augment the steps already in place (see Attachment #2). This plan will be continuously assessed and revised based upon the effectiveness of our interventions and input from clinical staff.

3. Diversion Summary Report

Please see attachment.

San Francisco General Hospital

Diversion Report

August 2002

EXECUTIVE SUMMARY

The Emergency Department [ED] recorded 46 episodes of diversion for 244 hours representing a rate of 32.8% in **August 2002**. This is a 4.3% increase in diversion since **July 2002**.

The 46 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from Previous Month
Total Diversion	46	244	32.8	4.3%
Trauma Override	6	17.25	2.3	.8%

The ED was impacted by capacity and high patient acuity during the episodes of Total Diversion. During this time, **275** patients were pending admission to inpatient beds [ICU-23, 4B/StepDown-134, MedSurg-116, 2-Isolation]. **In August 2001, the ED was on diversion 38% of the month. Trauma Override was invoked 3% of the month in August 2001.**

Total Diversion was recorded for 46 episodes, a total of 244 hours or a 32.3% rate for August 2002, and a 4.3% increase in Total Diversion since July 2002. While on Total Diversion the ED held **275** patients in **August 2002**. While on Total Diversion in **August 2001**, the ED held **302** patients awaiting inpatient beds.

Trauma Override was recorded for 6 episodes in August 2002. This is a .8% increase in Trauma Override since July 2002. While on Trauma Override the ED held **57** patients in **August 2002**. While on Trauma Override in **August 2001**, the ED held **48** patients awaiting inpatient beds.

Trauma Override Summary

The Emergency Department recorded 6 episodes of Trauma Override for 17.25 hours, a percentage of 2.3% for the month of August.

Date	Length	Summary of Event
08/08/02	1847-2103 (2h 16m)	911-1 912-2 910-0
08/12/02	1945-2045 (1h)	911-0 912-4 910-0
08/13/02	2245-0310 (4h 25m)	911-2 912-2 910-0
08/16/02	2200-0100 (3h)	911-1 912-2 910-0
08/25/02	1535-1600	911-0

	(25m)	912-2 910-0
08/30/02	1522-2131 (6h 9m)	911-1 912-3 910-0

DEFINITIONS:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSS Definitions:

Total Diversion:

When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override:

When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Sharon Kennedy R.N.
Base Hospital Coordinator

San Francisco General Hospital
Emergency Department
August 2002
Total Diversion Summary

In August, the Emergency Department recorded 46 episodes of Total Diversion for 244 hours, a percentage of 32.8% for the month.

Date	Length	Summary of Event
08/01/02	1830-1940 (1h 10m)	38 patients in the ED Admits: 7-4B ED waiting room: 12 urgent patients
08/01/02	0000-0350 (3h 50m)	37 patients in the ED Admits: 1-ICU; 3-4B; 1-Floor ED waiting room: 7 urgent patients
08/01/02	2255-0155 (3h)	37 patients in the ED Admits: 10-4B; 2-Floor ED waiting room: 20 urgent patients
08/02/02	0920-1305 (3h 45m)	34 patients in the ED Admits: 1-ICU; 4-4B; 7-Floor ED waiting room: 4 urgent patients
08/02/02	1530-2115 (5h 45m)	33 patients in the ED Admits: 1-ICU; 7-4B; 3-Floor ED waiting room: 3 urgent patients
08/02/02	2220-0037 (2h 17m)	37 patients in the ED Admits: 3-4B; 7-Floor ED waiting room: 8 urgent patients
08/03/02	2040-2300 (2h 20m)	33 patients in the ED Admits: 2-4B ED waiting room: 3 urgent patients
08/03/02	2347-0515 (5h 28m)	34 patients in the ED Admits: 5-4B; 4-Floor ED waiting room: 5 urgent patients
08/04/02	1235-1520 (2h 35m)	31 patients in the ED Admits: 1-4B ED waiting room: 4 urgent patients
08/04/02	2045-0101 (4h 16m)	37 patients in the ED Admits: 1-4B; 3-Floor ED waiting room: 4 urgent patients
08/05/02	1432-0030 (9h 58m)	34 patients in the ED Admits: 7-4B ED waiting room: 9 urgent patients
08/07/02	1225-1815 (5h 50m)	35 patients in the ED Admits: 3-4B; 4-Floor ED waiting room: 4 urgent patients
08/08/02	1500-0310 (12h 10m)	36 patients in the ED Admits: 3-4B; 2-Floor ED waiting room: 10 urgent patients
08/09/02	1245-1615 (4h 30m)	35 patients in the ED Admits: 2-4B ED waiting room: 10 urgent patients
08/09/02	2350-0827 (8h 37m)	39 patients in the ED Admits: 2-ICU; 5-4B; 3-Floor ED waiting room: 16 urgent patients
08/10/02	1815-0620 (12h 5m)	37 patients in the ED Admits: 3-4B; 8-Floor ED waiting room: 6 urgent patients
08/11/02	2130-0245 (5h 15m)	36 patients in the ED Admits: 2-4B; 5-Floor ED waiting room: 6 urgent patients
08/12/02	1604-0610	41 patients in the ED Admits: 1-ICU; 1-4B

	(14h 6m)	Admits: 7 urgent patients
08/13/02	1357-2130 (7h 33m)	35 patients in the ED Admits: 6-4B; 1-Floor ED waiting room: 6 urgent patients
08/13/02	2230-2242 (12m)	39 patients in the ED Admits: 1-ICU; 4-4B; 5-Floor ED waiting room: 6 urgent patients
08/14/02	1700-2109 (3h 9m)	37 patients in the ED Admits: 1-4B; 5-Floor ED waiting room: 6 urgent patients
08/15/02	1715-2115 (4h)	37 patients in the ED Admits: 1-ICU; 2-4B; 4-Floor ED waiting room: 6 urgent patients
08/15/02	2215-0215 (4h)	34 patients in the ED Admits: 1-ICU; 3-4B; 1-Floor ED waiting room: 12 urgent patients
08/16/02	1356-0400 (14h 4m)	32 patients in the ED Admits: 1-ICU; 3-4B; 2-Floor ED waiting room: 11 urgent patients
08/18/02	0322-0422 (1h)	36 patients in the ED Admits: 0 (<i>checked with Charge Nurse</i>) ED waiting room: 8 urgent patients
08/19/02	1555-1910 (3h 15m)	40 patients in the ED Admits: 3-4B; 3-Floor ED waiting room: 9 urgent patients
08/19/02	2000-2225 (2h 25m)	32 patients in the ED Admits: 3-4B; 2-Floor ED waiting room: 4 urgent patients
08/20/02	1027-1305 (1h 38m)	38 patients in the ED Admits: 1-4B; 2-Floor ED waiting room: 10 urgent patients
08/20/02	1345-1555 (2h 10m)	37 patients in the ED Admits: 1-ICU; 2-4B; 4-Floor ED waiting room: 15 urgent patients
08/20/02	1756-1910 (1h 14m)	38 patients in the ED Admits: 1-4B; 6-Floor ED waiting room: 8 urgent patients
08/21/02	1125-1407 (2h 42m)	36 patients in the ED Admits: 1-ICU; 2-4B ED waiting room: 7 urgent patients
08/21/02	2000-2230 (2h 30m)	35 patients in the ED Admits: 2-ICU; 2-4B; 3-Floor ED waiting room: 4 urgent patients
08/22/02	1250-0555 (17h 5m)	34 patients in the ED Admits: 3-4B; 1-Floor ED waiting room: 13 urgent patients
08/23/02	1045-2130 (10h 45m)	36 patients in the ED Admits: 6-4B; 2-Floor ED waiting room: 4 urgent patients
08/24/02	1530-1800 (2h 30m)	36 patients in the ED Admits: 2-4B; 3-Floor ED waiting room: 5 urgent patients
08/25/02	0400-0600 (2h)	37 patients in the ED Admits: 1-ICU; 1-4B; 3-Floor ED waiting room: 8 urgent patients
08/25/02	1230-1800 (5h 30m)	34 patients in the ED Admits: 2-ICU; 3-4B; 1-Floor ED waiting room: 4 urgent patients
08/25/02	2140-2240 (1h)	31 patients in the ED Admits: 2-4B ED waiting room: 4 urgent patients
08/26/02	1320-0130 (12h 10m)	37 patients in the ED Admits: 1-ICU; 2-4B; 1-Floor ED waiting room: 10 urgent patients
08/27/02	1358-1745 (3h 47m)	37 patients in the ED Admits: 1-ICU; 4-4B; 4-Floor; 2-Isolation ED waiting room: 4 urgent patients
08/27/02	2110-2350	35 patients in the ED Admits: 1-4B; 4-Floor

	(2h 40m)	ED waiting room: 13 urgent patients
08/28/02	1240-1730 (4h 50m)	32 patients in the ED Admits: 1-ICU; 2-4B; 3-Floor ED waiting room: 8 urgent patients
08/29/02	1024-1357 (3h 33m)	37 patients in the ED Admits: 1-ICU; 4-4B; 2-Floor ED waiting room: 2 urgent patients
08/29/02	2100-0002 (3h 2m)	37 patients in the ED Admits: 1-4B; 3-Floor ED waiting room: 7 urgent patients
08/30/02	1340-2130 (7h 51m)	36 patients in the ED Admits: 2-ICU; 1-4B ED waiting room: 2 urgent patients
08/31/02	1515-0125 (10h 10m)	36 patients in the ED Admits: 2-Floor ED waiting room: 10 urgent patients

Actions Taken by the Department of Psychiatry to Reduce Assaults 2000 -2002

SMART- Safety Management and Response Training

- Changes in the PART Curriculum to include diagnostic categories prone to assault. Named changed to SMART.
- Institutional Police now attending SMART Training
- SMART Update every two years for every staff for 4 hours per session, these sessions include a review of defensive and containment maneuvers as well as verbal de-escalation skills
- Every staff is required to do a return demonstration of restraint application in orientation..

Prevention

- Coping skills form developed and implemented to identify interventions that may be helpful for individual patients in controlling violence.
- Refurbished the inpatient units to provide and homelike and comfortable environment for the patients. (research shows that a clean, homelike environment with snacks available will reduce assaults)
- Added definitions of precautions to the Admission Orders sheets so that patient came up on appropriate levels of precautions.
- MOU developed in conjunction with the Institutional Police to clarify roles of the Institutional Police and the unit staff when intervening violent situations.

After an Assault

- Active involvement of the Chief and Deputy Chief of the Department of Psychiatry with the District Attorney's office in pursuing prosecution of select patients who assaulted staff in the hospital
- Staff and patient who are assaulted are encouraged to file a police report when there is any question of a criminal assault
- The Department provides a psychotherapist with a specialty in PTSD to provide post assault counseling for staff who have been assaulted or have been effected by violence on the units.
- Institutional Police actively involved in critical incident reviews related to assaults
- Specialized treatment plans are developed for every patient who is on Assault 3 and/or has been violent on the unit
- Plan was made and implemented to find placement for patients who were assaultive that had been here for an extended period of time

Education and Planning

- Frequent care conferences to communicate and develop plans for the assaultive patient.
- Psychopharmacology Seminar Series which has included classes in care of the aggressive/violent patient
- Case Conferences department wide utilizing patients with significant histories of violence and the psychodynamic theories regarding the care of these patients.
- Educated staff about working with the brain impaired patients and techniques to reduce assaultive events.
- Looked at patterns of prn use and educated all staff and M.D.s on prn use and trends in assault

ACTION PLAN TO DECREASE THE INCIDENCE AND SEVERITY OF ASSAULT IN PSYCHIATRY

August 27, 2002

1. Personal Alarm Pilot will be initiated.
2. Increased Institutional Police presence will be instituted, including unit rounding and decreased response time.
3. Staff involvement will be increased in the process to recommend in favor of or against the prosecution of an assault case by the District Attorney.
4. An additional night shift nursing staff position will be added to provide support in admitting new patients and to provide extra coverage warranted by patient acuity.
5. Criteria for admission of a patient to the inpatient service during night shift will be reviewed to determine if changing our current clinical review of patients prior to admission could result in decreased risk of assault.
6. Medication prescribing practice for the treatment of agitation will be thoroughly assessed. In-service classes for attending psychiatrists and nursing staff targeting the use of medications for the agitated and potentially violent patient will be provided.
7. SMART (Safety Management and Assault Training) curriculum will continue to emphasize that staff should take any appropriate action necessary to protect and defend themselves in those dangerous situations in which all other measures have failed. Targeted SMART refresher classes on "de-escalation", "limit-setting", and other clinical interventions to decrease the risk of assault will be provided.
8. Signage will be posted prominently on units indicating that violence will not be tolerated.
9. Psychiatry Department will advocate with SFGH administration to increase the allotment of food snacks for inpatients. Food is a highly effective intervention for very disturbed clients.
10. Post Assault Treatment Planning will occur directly following an assault to address the immediate needs of the affected staff and make appropriate changes in the treatment of the assaultive patient.
11. A Post Assault Critical Incident Review Board will be established to evaluate specific incidents of staff assault. Findings will be reported to the SFGH Management Response Team (MRT).
12. The Department of Public Health has standardized the assault pay process for all nursing staff and with prompt processing of assault pay requests.

Department of Psychiatry leadership will continue to seek feedback from front line nursing staff regarding what post-assault supportive interventions.

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

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AGENDA

**JOINT CONFERENCE COMMITTEE
FOR
SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING**

**Tuesday, October 8, 2002
3:45 p.m. - 5:30 p.m.**

**1001 Potrero, Conference Room #2A6
San Francisco, CA 94110**

DOCUMENTS DEPT

OCT 4 2002

Commissioner Lee Ann Monfredini, Chair
Commissioner Harrison Parker, Sr. DDS

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- 1) **CALL TO ORDER**
- 2) **PROPOSED ACTION:** **APPROVAL OF MINUTES OF SEPTEMBER 10, 2002**
**Minutes of September 10, 2002*
- 3) **FOR DISCUSSION:** **SFGH INSTITUTIONAL MASTER PLAN/REBUILD UPDATE**
(Anthony G. Wagner, Exec. Admin. Community Health Network)
**Update*
- 4) **PUBLIC COMMENT****
- 5) **CLOSED SESSION**
 - A) **Public Comments on All Matters Pertaining to the Closed Session**
 - B) **Vote on Whether to Hold a Closed Session**

- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **APPROVAL OF CLOSED SESSION MINUTES OF SEPTEMBER 10, 2002**

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE**

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: **CONSIDERATION OF CREDENTIALING MATTERS**
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION AND POSSIBLE ACTION: **MEDICAL STAFF REPORT**
J. Renee Navarro, M.D., Chief of Staff

- D) Reconvene in Open Session

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

6) **ADJOURNMENT**

- * Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.
- ** Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building. Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

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Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

DOCUMENTS DEPT.

Tuesday, October 8, 2002
3:45 p.m. - 5:30 p.m.

1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

NOV 12 2002

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1) CALL TO ORDER

The meeting was called to order by Commissioner Lee Ann Monfredini at 3:47 p.m. Commissioner Monfredini introduced Commissioner Parker as the new member of the San Francisco General Hospital Joint Conference Committee.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner Harrison Parker, Sr. DDS

Staff: Anne Chang, Sue Currin, Myra Garcia, Valerie Inouye, John Kanaley, John Luce, M.D., Beth Maloney, Alison Moed, Rene Navarro, M.D., Valerie Ng, M.D., Gene O'Connell, Roland Pickens, Hiro Tokubo, Carlos Villalva, Chris Wachsmuth.

Ms. O'Connell distributed the Hospital Healthcare Update Report (Attachment A) and Sue Currin distributed the Patient Care Services Report (Attachment B). If Committee members have questions about either of these two documents they can raise them at the November meeting.

2) APPROVAL OF MINUTES OF SEPTEMBER 10, 2002

Action Taken: The Committee approved the minutes of the September 10, 2002 meeting.

3) SFGH INSTITUTIONAL MASTER PLAN/REBUILD UPDATE

John Kanaley introduced Ignatius Tsang, the project director of the SOM/Tsang joint venture. Mr. Tsang updated the Committee on the development Institutional Master Plan (IMP). The overall objective is to define the leading option for the IMP by January 2003. The near-term objective for the October 15th Health Commission meeting is to develop baseline projections of demand in all areas that will impact IMP planning so they may be used to create a variety of program-based scenarios. Mr. Tsang emphasized that the IMP does not just encompass the hospital, but includes ambulatory care, research, etc. However, SB 1953 relates specifically to the acute care hospital.

Jack Parker, one of the project consultants, said they plan to have six scenarios developed by December for consideration by the Health Commission, with final Commission approval on February 18th. The IMP is not finalized until after the bond measure is passed.

Charlie Cosovich with Kurt Salmon Associates gave an overview of baseline development. For each category they need to answer six questions: where do the numbers come from; what are the numbers; how are the numbers best split apart for scenario development; what are the sensitivities; how do the numbers translate to space figures; and what are the space figures.

Mr. Cosovich then gave detailed descriptions about the baseline development for Acute Care, Ambulatory Care and Diagnostic and Treatment services. The next steps in the process are to develop research and education demand projections, develop support and administration requirements, develop scenarios, translate all service units into facilities programs and develop concept and proposals.

Dr. Luce asked how UC fits into this process, and how the Department is going to work through that bureaucracy. Jim Bucher from DPW replied that there have been high-level meetings with UCSF and there will be scenarios that involve co-location. Carlos Villalva added that UC is evaluating a number of scenarios. By January they have said they would have two options. However they then must go through the UC process. If there is serious discussion about co-location, DPH may need to look at either changing the bond date or changing the legislatively required timeline for compliance.

Chris Wachsmuth asked where clinical and line staff would have input into the planning process. Roland Pickens added that SFGH staff, including facilities, did not have the opportunity to validate the numbers that were part of the Lewin report. Mr. Kanaley said that they are committed to involving staff, clinicians and others in the IMP process. Ms. O'Connell said that the SFGH community feels like they could have been more involved in the development of the Lewin Report but with this process, she feels good that SFGH will really be involved.

Commissioners' Comments

- Commissioner Monfredini said that there were a few assumptions that were not in the Lewin Report: people will live longer; human nature does not change so there will always be violence and addiction; there will always be people living below the poverty level; and medical cures will happen and will have many impacts. The timeframe in which DPH has to work is different from UCSF's timeline, which makes the joint campus scenario unlikely. She asked if staff would have a price tag for the project by March, and said that the

Department and Commission need to be very clear, thorough and honest with the voters about what the costs and risks are.

- Commissioner Parker said we that first we have to convince the public of the need for this facility. Trouble arises when costs are underestimated. It happens on so many projects that seem to be more expensive that originally projected even before construction begins. We need to let people know that we are looking out for the public's health and finances.

4) **PUBLIC COMMENT**

None.

5) **CLOSED SESSION**

A) **Public Comments on All Matters Pertaining to the Closed Session**

None.

B) **Vote on Whether to Hold a Closed Session**

Action Taken: The Committee voted to hold a closed session. The Committee went into closed session at 5:07 p.m.

Present in closed session were the present in open session except for Valerie Inouye, Carlos Villalva and Gene O'Connell. Rene Navarro left at 5:10 p.m.

C) **Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1**

**APPROVAL OF CLOSED SESSION MINUTES OF
SEPTEMBER 10, 2002**

Action Taken: The Committee approved the September 10 Closed Session minutes.

**CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE,
QUALITY ASSURANCE**

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

CONSIDERATION OF CREDENTIALING MATTERS

J. Renee Navarro, M.D., Chief of Staff

Action Taken: The Committee approved the Credentials report.

MEDICAL STAFF REPORT

J. Renee Navarro, M.D., Chief of Staff

This report was not presented.

D) **Reconvene in Open Session**

The Committee reconvened in open session at 5:35 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in closed session.

6) **ADJOURNMENT**

The meeting was adjourned at 5:36 p.m.



Michele M. Olson
Health Commission Executive Secretary

Attachments (20

HOSPITAL HEALTHCARE UPDATE REPORT

Presented to the JCC-SFGH on October 8, 2002

By Gene Marie O'Connell, SFGH Executive Administrator

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Program Updates

City Budget Freeze and Potential Reductions

Given State budget reductions and the uncertainty of their impact on the city's 2002-2003 budget, the Mayor's Budget Director has placed certain SFGH capital projects and equipment expenditures on reserve until further notice. Most of these expenditures are to replace outdated and broken equipment that directly impact patient care and are required by regulation to maintain and upgrade. Examples include replacing broken bedside nurse call systems, replacing a faulty fire alarm system at Tom Waddell Health Center, replacing broken x-ray equipment, and replacing unsupported defibrillators. SFGH has prepared justifications for priority expenditures and are working with DPH to try to remove these items from the reserve list.

The Mayor's Office has also indicated the potential need to reduce the general fund by 3% this year and 6% next year, and have asked DPH to identify potential service cuts if needed. If enacted, SFGH's interpreter services, pharmacy formulary, and Mental Health Rehabilitation Facility could be impacted.

Helipad Feasibility

SFGH is the only Level 1 Trauma Center available for the over 1.5 million people living and working in San Francisco and northern San Mateo County. Over 2800 adult and pediatric patients a year are treated for injuries requiring the services of a Level 1 Trauma Center. However, San Francisco and its Level 1 Trauma Center are the only locations within the top 25 municipalities in the United States without aero-medical access for the people who live, work, and recreate in the city. The inability to air transport patients into and out of San Francisco and its Trauma Center compromises SFGH's ability to respond to critically injured patients whose needs are best served at a Level 1 Trauma Center. To better respond to all trauma patients within this region and maintain American College of Surgeons verification as a Level 1 Trauma Center, SFGH is conducting a needs assessment and feasibility study to determine the need for aero-medical access and if a helipad can be located at the SFGH campus. The architectural firm of Gerson/Overstreet has been retained on city contract with DPH to conduct the needs assessment, feasibility analysis, and community outreach for this important aero-medical access study. An SFGH team led by Chris Wachsmuth, SFGH Administrator for Emergency and Trauma Services, includes staff from Facility Planning, the Trauma Program, UCSF Dean's Office, the EMS Agency, and Planning staff involved with the SFGH Rebuild Steering Committee. Dr. Robert Mackersie, Trauma Director, is also participating in this project. The project is divided into four main components:

- 1) Aeromedical Needs Assessment
- 2) Feasibility Analysis for the SFGH Campus
- 3) Noise and Safety Analysis for the SFGH Campus
- 4) Community Outreach

Work began on September 20, and will continue through January 31, 2003 culminating with a presentation before the full Health Commission in February 2003. This final presentation will complete the work originated by the Health Commission's resolution accepting the San Francisco Trauma Care System Plan in August 2001.

Opiate Treatment Outpatient Program Accreditation

On October 3, the Commission on Accreditation of Rehabilitation Facilities (CARF) conducted an accreditation visit of SFGH's Opiate Treatment Outpatient Program (OTOP). Managed by the UCSF Division of Substance Abuse and Addictive Medicine, OTOP provides methadone maintenance to patients to reduce their dependency to heroin. CARF is one of four nationally approved accreditation providers for opioid treatment programs, which are now Federally required to complete an accreditation process by 2003. Surveyors gave positive feedback to staff on its operations and the support demonstrated by administration for the program.

JCAHO Appeal Results, New Accreditation Model

For the 2002 CALS/JCAHO survey, SFGH received 12 Type 1 recommendations, 8 of which the SFGH Executive Committee decided to appeal. On September 18, SFGH was notified that JCAHO had accepted 7 of 8 appeals, 3 of which were deleted altogether, meaning those Type 1 recommendations should never have been issued. This increased SFGH's grid score from 84 to 87 and left only 5 Type I Recommendations that require six-month progress reports. A summary of the Type 1 recommendations and their statuses are attached.

On September 30, Dr. Russell Massaro, Executive Vice President of Accreditation Operations at JCAHO, met with the SFGH Executive Committee to unveil and gather input around JCAHO's new accreditation model. This model would eliminate scoring, focus on self-assessment, and survey organizations based on the quality of care delivered to patients at different points in the system rather than assessing strict adherence to standards. By the 18th month point of its triennial cycle, an organization is expected to self identify its level of compliance with customized standards that would be posted electronically. A Statement of Correction would be submitted for those standards that the organization judges itself to be out of compliance. JCAHO would then conduct a 36th month survey to test the carrying out of the Statement of Corrections and compliance with other standards by pulling a sample of medical charts and assessing the care provided to those patients in each unit and site. SFGH can access a copy of the self-assessment survey for its next survey cycle in April 2005; however, JCAHO does not plan to accept self- assessments electronically until July 2005.

2002-2003 SFGH Strategic Goals Established

On August 8, the SFGH Executive Committee participated in a retreat that established goal setting for the 2002-2003 fiscal year. 9 strategic goals have been identified across the hospital. Broadly, those goals are:

- o Rebuilding SFGH
- o Maintaining a Level 1 Trauma Center designation
- o Completing a helipad feasibility study
- o Developing and opening the Avon Comprehensive Breast Cancer Center
- o Maximizing revenue
- o Implementing information systems projects
- o Placing mental health patients at the appropriate level of care
- o Maintaining JCAHO readiness
- o Decreasing turnover of staff and vacancies

Workgroups have been established to address each of these goals and develop action plans for the year.

**2002 JCAHO TYPE I RECOMMENDATIONS
SEPTEMBER 25, 2002 – UPDATE**

Grid score increased from 84 to 87

<u>TYPE I RECOMMENDATION</u>	<u>APPEAL STATUS/DECISION</u>
# 1. Trauma Videotaping	Appeal accepted; score changed from 3 to 2; Type I reduced to Supplemental Recommendation
# 2. Advance Directives	Appeal accepted; Type I deleted (Type I should not have been issued in the first place)
# 3. Nutrition Assessment	Appeal accepted; score changed from 3 to 2; Type I reduced to Supplemental Recommendation
# 4. Pain Assessment/Management	NOT appealed; written progress report due on November 30, 2002
# 5. Interdisciplinary Care Plans	Appeal accepted; Type I deleted (Type I should not have been issued in the first place)
# 6. Appropriate Control of Medications	Appeal not accepted; written progress report due on March 15, 2003
# 7. Smoking Policy	NOT appealed; written progress report due on November 30, 2002
# 8. Biomedical Equipment/Preventive Maintenance	Appeal accepted; score changed from 3 to 2; Type I reduced to Supplemental Recommendation
# 9. Age-Specific Competencies	Appeal accepted; score changed from 3 to 2; Type I reduced to Supplemental Recommendation
#10. Telephone/Verbal Orders	NOT appealed; written progress report due on November 30, 2002
#11. Authentication of Dictated Reports by Author	Appeal accepted; Type I deleted (Type I should not have been issued in the first place)
#12. Assessment for prior and current hobbies (long-term care)	NOT appealed; written progress report due on November 30, 2002

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 10/8/02

Sue Currin, RN, MS, Chief Nursing Office

1. GERIATRIC CARE AT SFGHMC

A multidisciplinary meeting was held in August to discuss the needs of the geriatric population at SFGHMC. In this meeting, the possibility of linking our clinical services with the VA Medical Center Geriatric Fellowship Program was discussed. Further meetings occurred in September and a plan for a Geriatric Consult Team was developed.

The Geriatrics Consult Team will be comprised of the following core team members: Geriatrics Fellow, Geriatrics/Medicine Attending, Geriatric Clinical Nurse Specialist, Medicine Consult Resident, and Pharmacist. Additional participants may include Social Work, RN/LVN staff, PT/OT/ST, Psychiatry Consult Liaison, and other specialties as appropriate to enhance age-appropriate care to our geriatric inpatient population, while providing continued education of our residents and staff.

The Geriatrics Consult Team will provide consultation one morning per week and meet to discuss their findings. The Geriatrics Fellow and Medicine Consult Resident will write up the recommendations of the interdisciplinary team while the Geriatric Clinical Nurse Specialist serves as a mentor and liaison to the nursing staff regarding age-specific recommendations for care. The Geriatrics Fellow will also provide one lecture per month and will attend morning report as time permits.

Patients will be identified for the consult team by the Geriatric CNS assigned to the Medical Behavior Program and/or the Geriatrics/Medicine Attending. Criteria will include older patients experiencing geriatric syndromes that would benefit from interdisciplinary treatment/discharge planning. Examples of geriatric syndromes might include delirium, dementia, falls, gait disorders, sensory impairments, failure to thrive, urinary incontinence, pain management issues specific to the geriatric population, and sleep problems.

The goal of the Geriatric Consult Service is to eventually develop a long-term presence for Geriatrics at SFGHMC. The program must be able to show how it adds value for the patients and staff. Measurements of success might include patient and patient family satisfaction questionnaires, nursing staff questionnaires regarding knowledge of assessment and management of geriatric syndromes pre/post intervention, and Medicine Resident and Geriatric Fellow Evaluations.

2. OPERATING ROOM

The Operating Room combined rigorous recruitment with in-house Training Programs to reduce their vacancy rate from 16% to 2.7%. Four RNs were trained in two 6-month programs utilizing the AORN training module. The SFGH OR Nursing Management staff will be interviewed by the Journal of OR Management to discuss their recruitment and retention strategies.

Attachment B, p. 1

3. **CONDITION YELLOW/RED**

Condition Yellow (Definition: 10 or more patient waiting for admission) has been activated 17 times for a total of 157 hours and 30 minutes in 2002. Positive outcomes of Condition Yellow include:

- No OR, Interventional Radiology or Cardiac Cath procedures have been cancelled because of overcrowding
- Orders for discharge are being written earlier and there has been an increase in the utilization of the Discharge Lounge for patients waiting for rides, prescriptions, etc.
- We have only progressed to Condition Red once in 2002.
- Clinic admissions are given priority for beds and patients are not routinely transferred to the ED to wait for admission.

SFGH has been on Condition Red (Definition: Only 1 critical care beds with no pending transfer, PACU full and > 10 patients waiting for beds) once for a 2 hour 50 minute period in 2002. At the time of Condition Red there were approximately 14 patients waiting for admission to the 4B-Stepdown Unit, 4 patients requiring ICU placement and 6 patients waiting for medical-surgical admissions.

Several key follow-up issues will be worked on by subgroups:

- a. Priority clinic appointments for patients discharged from the ED and Inpatient Units
- b. Condition Yellow/Red actions between 8:00 PM and 7:00 AM

4. **VASCULAR ACCESS DEVICES**

Registered Nurses with additional specialized training will begin to insert Peripheral Intravenous Central Catheters (PICC) beginning in November, 2002. PICC lines are used when a patient's peripheral access is difficult and/or for the administration of intravenous medications that could potentially damage or cause complications to peripheral veins and surrounding tissue.

The Vascular Access Nurses can perform PICC line insertions under the California Nurse Practice Act. The use of ultrasound equipment by the Vascular Access Nurses to aid in the insertion procedure is an overlap function with medicine. This overlapping activity requires standardized procedures that include guidelines stating specific conditions under which the Vascular Access Nurse must consult with the physician.

Rivka Livni, RN has been selected as the new SFGH Adult Vascular Access Nurse. Nora Breenan RN, CNS-Pediatrics, Francesca Cunningham, RN-Newborn Nursery, and Hyjasmin Blanco-Powers, RN-Infusion Center were also trained to insert PICC lines. The Vascular Access Nurses will be proctored by Dr. Shelly Marder, Interventional Radiologist.

5. **DIVERSION SUMMARY REPORT**

Please see attachment.

DIVERSION REPORT

September 2002

1. EXECUTIVE SUMMARY

The Emergency Department [ED] recorded 40 episodes of diversion for 228 hours representing a rate of 31.7% in **September 2002**. This is a 1.1% decrease in diversion since **August 2002**.

The 40 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from Previous Month
Total Diversion	40	228	31.7	1.1%
Trauma Override	6	22	3	.7%

The ED was impacted by capacity and high patient acuity during the episodes of Total Diversion. During this time, 250 patients were pending admission to inpatient beds [ICU-23, 4B/StepDown-83, MedSurg-144]. In **September 2001**, the ED was on diversion 22.5% of the month. Trauma Override was invoked 3% of the month in **September 2001**.

Total Diversion was recorded for 40 episodes, a total of 228 hours or a 31.7% rate for September 2002, and a 1.1% decrease in Total Diversion since August 2002. While on Total Diversion the ED held 250 patients in **September 2002**. While on Total Diversion in **September 2001**, the ED held 302 patients awaiting inpatient beds.

Trauma Override was recorded for 6 episodes in August 2002. This is a .7% increase in Trauma Override since August 2002. While on Trauma Override the ED held 37 patients in **September 2002**. While on Trauma Override in **September 2001**, the ED held 96 patients awaiting inpatient beds.

2. DEFINITIONS:

SFGH internal trauma activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSS definitions:

Total diversion: When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override: When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria. The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Sharon Kennedy R.N.
Base Hospital Coordinator

3. TRAUMA OVERRIDE SUMMARY

The Emergency Department recorded 6 episodes of Trauma Override for 22 hours, a percentage of 3% for the month of September.

Date	Length	Summary of Event
09/04/02	1850-0100 (6h 10m)	911-1 912-0 910-0
09/15/02	0137-0230 (53m)	911-1 912-3 910-0
09/16/02	1335-1539 (1h 44m)	911-1 912-2 910-0
09/22/02	2305-0214 (3h 9m)	911-1 912-2 910-0
09/23/02	1508-2015 (5h 7m)	911-1 912-1 910-0
09/24/02	1800-2240 (4h 40m)	911-0 912-0 910-0

4. TOTAL DIVERSION SUMMARY

In September, the Emergency Department recorded 40 episodes of Total Diversion for 228 hours, a percentage of 31.7% for the month.

Date	Length	Summary of Event
09/01/02	1700-0140 (8h 40m)	37 patients in the ED Admits: 2-4B; 3-Floor ED waiting room: 3 urgent patients
09/02/02	1520-0150 (10h 30m)	38 patients in the ED Admits: 3-Floor ED waiting room: 4 urgent patients
09/03/02	1515-1740 (2h 25m)	32 patients in the ED Admits: 3-4B ED waiting room: 4 urgent patients
09/04/02	1315-0100	40 patients in the ED Admits: 2-ICU; 4-4B; 4-Floor

	(11h 45m)	ED waiting room: 6 urgent patients
09/05/02	1042-1237 (1h 55m)	36 patients in the ED Admits: 5-4B; 3-Floor ED waiting room: 2 urgent patients
09/05/02	1447-2300 (8h 13m)	39 patients in the ED Admits: 5-4B; 3-Floor ED waiting room: 5 urgent patients
09/06/02	0255-0600 (3h 5m)	36 patients in the ED Admits: 1-ICU; 5-4B; 4-Floor ED waiting room: 8 urgent patients
09/06/02	1230-2300 (10h 30m)	36 patients in the ED Admits: 5-4B; 4-Floor ED waiting room: 9 urgent patients
09/07/02	0040-0540 (5h)	38 patients in the ED Admits: 1-4B; 7-Floor ED waiting room: 14 urgent patients
09/07/02	1820-0444 (10h 24m)	32 patients in the ED Admits: 1-ICU; 1-4B; 6-Floor ED waiting room: 7 urgent patients
09/08/02	1350-2145 (7h 55m)	39 patients in the ED Admits: 3-4B; 3-Floor ED waiting room: 7 urgent patients
09/09/02	1115-0330 (16h 15m)	32 patients in the ED Admits: 1-ICU; 3-4B- 5-Floor ED waiting room: 3 urgent patients
09/10/02	0827-1005 (1h 38m)	35 patients in the ED Admits: 10-Floor ED waiting room: 10 urgent patients
09/10/02	1353-1920 (5h 27m)	34 patients in the ED Admits: 1-ICU; 1-4B; 10-Floor ED waiting room: 15 urgent patients
09/10/02	2139-0045 (4h 6m)	35 patients in the ED Admits: 1-ICU; 1-4B; 7-Floor ED waiting room: 3 urgent patients
09/11/02	1340-1634 (3h 14m)	36 patients in the ED Admits: 2-4B; 2-Floor ED waiting room: 6 urgent patients
09/13/02	1215-2230 (10h 15m)	35 patients in the ED Admits: 1-ICU; 3-Floor ED waiting room: 10 urgent patients
09/14/02	1020-0230 (16h 10m)	36 patients in the ED Admits: 2-4B; 2-Floor ED waiting room: 5 urgent patients
09/15/02	0333-0637 (3h 4m)	34 patients in the ED Admits: 1-4B; 5-Floor ED waiting room: 10 urgent patients
09/15/02	1815-2215 (4h)	32 patients in the ED Admits: 2-4B; 3-Floor ED waiting room: 2 urgent patients
09/16/02	1140-1351 (2h 11m)	30 patients in the ED Admits: 1-ICU; 3-4B; 2-Floor ED waiting room: 1 urgent patient
09/17/02	1815-2255 (4h 40m)	33 patients in the ED Admits: 1-ICU; 1-4B; 3-Floor ED waiting room: 11 urgent patients
09/18/02	0910-1140 (2h 30m)	39 patients in the ED Admits: 1-ICU; 1-Floor ED waiting room: 6 urgent patients
09/18/02	1435-1900 (4h 25m)	35 patients in the ED Admits: 3-Floor ED waiting room: 10 urgent patients
09/19/02	0950-1145 (1h 55m)	33 patients in the ED Admits: 1-ICU; 6-Floor ED waiting room: 4 urgent patients
09/19/02	1325-2225 (9h)	38 patients in the ED Admits: 1-4B; 6-Floor ED waiting room: 8 urgent patients
09/20/02	1805-2111 (3h 6m)	36 patients in the ED Admits: 5-4B; 1-Floor ED waiting room: 4 urgent patients

09/21/02	1630-1800 (1h 30m)	35 patients in the ED Admits: 2-ICU; 1-4B; 2-Floor ED waiting room: 6 urgent patients
09/22/02	2100-0300 (6h)	35 patients in the ED Admits: 1-ICU; 1-4B; 2-Floor ED waiting room: 4 urgent patients
09/23/02	1130-1355 (2h 25m)	31 patients in the ED Admits: 1-ICU; 1-4B ED waiting room: 6 urgent patients
09/23/02	1507-2027 (5h 20m)	36 patients in the ED Admits: 2-ICU; 4-4B; 2-Floor ED waiting room: 12 urgent patients
09/24/02	1400-1650 (2h 50m)	34 patients in the ED Admits: 1-ICU; 1-Floor ED waiting room: 4 urgent patients
09/24/02	1740-2240 (5h)	35 patients in the ED Admits: 1-ICU; 3-4B; 3-Floor ED waiting room: 5 urgent patients
09/25/02	2110-0230 (5h 20m)	37 patients in the ED Admits: 3-4B; 8-Floor ED waiting room: 15 urgent patients
09/25/02	1240-1825 (5h 45m)	38 patients in the ED Admits: 1-ICU; 2-4B ED waiting room: 13 urgent patients
09/26/02	1550-1840 (2h 50m)	38 patients in the ED Admits: 2-4B; 5-Floor ED waiting room: 4 urgent patients
09/27/02	1450-2234 (7h 44m)	34 patients in the ED Admits: 1-ICU; 8-4B; 1-Floor ED waiting room: 8 urgent patients
09/28/02	0205-0420 (2h 15m)	31 patients in the ED Admits: 1-4B; 4-Floor ED waiting room: 5 urgent patients
09/29/02	2115-0215 (5h)	37 patients in the ED Admits: 1-4B; 3-Floor ED waiting room: 4 urgent patients
09/30/02	1810-2205 (3h 55m)	36 patients in the ED Admits: 1-ICU; 4-Floor ED waiting room: 6 urgent patients

Actions Taken by the Department of Psychiatry to Reduce Assaults 2000 -2002

SMART- Safety Management and Response Training

- Changes in the PART Curriculum to include diagnostic categories prone to assault. Named changed to SMART.
- Institutional Police now attending SMART Training
- SMART Update every two years for every staff for 4 hours per session, these sessions include a review of defensive and containment maneuvers as well as verbal de-escalation skills
- Every staff is required to do a return demonstration of restraint application in orientation.

Prevention

- Coping skills form developed and implemented to identify interventions that may be helpful for individual patients in controlling violence.
- Refurbished the inpatient units to provide a more homelike and comfortable environment for the patients. (research shows that a clean, homelike environment with snacks available will reduce assaults)
- Added definitions of precautions to the Admission Orders sheets so that patient came up on appropriate levels of precautions.
- MOU developed in conjunction with the Institutional Police to clarify roles of the Institutional Police and the unit staff when intervening violent situations.

After an Assault

- Active involvement of the Chief and Deputy Chief of the Department of Psychiatry with the District Attorney's office in pursuing prosecution of select patients who assaulted staff in the hospital
- Staff and patient who are assaulted are encouraged to file a police report when there is any question of a criminal assault
- The Department provides a psychotherapist with a specialty in PTSD to provide post assault counseling for staff who have been assaulted or have been effected by violence on the units.
- Institutional Police actively involved in critical incident reviews related to assaults
- Specialized treatment plans are developed for every patient who is on Assault 3 and/or has been violent on the unit
- Plan was made and implemented to find placement for patients who were assaultive that had been here for an extended period of time

Education and Planning

- Frequent care conferences to communicate and develop plans for the assaultive patient.
- Psychopharmacology Seminar Series which has included classes in care of the aggressive/violent patient
- Case Conferences department wide utilizing patients with significant histories of violence and the psychodynamic theories regarding the care of these patients.
- Educated staff about working with the brain impaired patients and techniques to reduce assaultive events.
- Looked at patterns of prn use and educated all staff and M.D.s on prn use and trends in assault

**ACTION PLAN TO DECREASE THE INCIDENCE AND SEVERITY OF
ASSAULT IN PSYCHIATRY
August 27, 2002**

1. Personal Alarm Pilot will be initiated.
2. Increased Institutional Police presence will be instituted, including unit rounding and decreased response time.
3. Staff involvement will be increased in the process to recommend in favor of or against the prosecution of an assault case by the District Attorney.
4. An additional night shift nursing staff position will be added to provide support in admitting new patients and to provide extra coverage warranted by patient acuity.
5. Criteria for admission of a patient to the inpatient service during night shift will be reviewed to determine if changing our current clinical review of patients prior to admission could result in decreased risk of assault.
6. Medication prescribing practice for the treatment of agitation will be thoroughly assessed. In-service classes for attending psychiatrists and nursing staff targeting the use of medications for the agitated and potentially violent patient will be provided.
7. SMART (Safety Management and Assault Training) curriculum will continue to emphasize that staff should take any appropriate action necessary to protect and defend themselves in those dangerous situations in which all other measures have failed. Targeted SMART refresher classes on "de-escalation", "limit-setting", and other clinical interventions to decrease the risk of assault will be provided.
8. Signage will be posted prominently on units indicating that violence will not be tolerated.
9. Psychiatry Department will advocate with SFGH administration to increase the allotment of food snacks for inpatients. Food is a highly effective intervention for very disturbed clients.
10. Post Assault Treatment Planning will occur directly following an assault to address the immediate needs of the affected staff and make appropriate changes in the treatment of the assaultive patient.
11. A Post Assault Critical Incident Review Board will be established to evaluate specific incidents of staff assault. Findings will be reported to the SFGH Management Response Team (MRT).
12. The Department of Public Health has standardized the assault pay process for all nursing staff and with prompt processing of assault pay requests.

Department of Psychiatry leadership will continue to seek feedback from front line nursing staff regarding what post-assault supportive interventions.

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Edward A. Chow, M.D.
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Roma P. Guy, M.S.W.
Vice President

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HEALTH COMMISSION

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, November 12, 2002
3:45 p.m. - 5:30 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

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Commissioner Lee Ann Monfredini, Chair
Commissioner Harrison Parker, D.D.S.

- 1) CALL TO ORDER
- 2) PROPOSED ACTION: APPROVAL OF MINUTES OF OCTOBER 8, 2002 MEETING
**Minutes of October 8, 2002*
- 3) FOR DISCUSSION: HOSPITAL HEALTHCARE UPDATE
(Activities and operations of SFGHMC)
(Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center)
**Report*
- 4) FOR DISCUSSION: PATIENT CARE REPORT
(Sue Currin, RN, Chief Nursing Officer)
**Report*
- 5) FOR DISCUSSION: SFGH ANNUAL REPORT
(Gene O'Connell, Executive Administrator, SFGH)
**Report*

6) **PUBLIC COMMENT****

7) **CLOSED SESSION**

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **APPROVAL OF CLOSED SESSION MINUTES
OF OCTOBER 8, 2002**

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT,
QUALITY OF CARE, QUALITY ASSURANCE**

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: **CONSIDERATION OF CREDENTIALING MATTERS**
J. Renee Navarro, M.D., Chief of Staff

**FOR DISCUSSION
AND POSSIBLE
ACTION:** **MEDICAL STAFF REPORT**
J. Renee Navarro, M.D., Chief of Staff

D) Reconvene in Open Session

- 1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
- 2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

8) **ADJOURNMENT**

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building.

Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; and web site: www.sfgov.org/ethics.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: Donna_Hall@ci.sf.ca.us.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at: www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, November 12, 2002

3:45 p.m. - 5:30 p.m.

1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

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1) CALL TO ORDER

The meeting was called to order by Commissioner Monfredini at 3:45 p.m.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner Harrison Parker, D.D.S.

Staff: Anne Chang, Yuhum Digdigan, John Kanaley, Talmadge King, M.D., John Luce, M.D., Anson Moon, Renee Navarro, M.D., Valerie Ng, M.D., Gene O'Connell, Maureen O'Neil, Roland Pickens, Hiro Tokubo, Carlos Villalva, Chris Wachsmuth.

2) APPROVAL OF MINUTES OF OCTOBER 8, 2002 MEETING

Action Taken: The Committee approved the minutes of the October 8, 2002 meeting.

3) HOSPITAL HEALTHCARE UPDATE

Gene O'Connell, Executive Administrator, San Francisco General Hospital Medical Center, presented the Hospital Healthcare Update.

Program Updates

SFGHMC Rebuilt Update (see presentation materials)

Temporary Power Outage at SFGHMC

On Thursday, November 7, PG&E power was disrupted to the SFGHMC Campus at around 8:45 p.m. as a result of a downed tree on 22nd Street and Arkansas. Watch Engineers immediately transferred to emergency power delivered from the power plant's steam generator, and Chief Engineers were called to the facility. At around 12:30 a.m., a radiology equipment room began approaching temperatures of 90 degrees Fahrenheit. In an attempt to transfer emergency power to an air conditioning unit, the extreme load on the generator caused the power plant to temporarily disable, causing a total power failure for 18 minutes before the power plant was restored. During that time, there were no adverse outcomes for patients. There was no sign of malfunction in backup battery systems for patient medical equipment. From 12:55 to 2:05 a.m., SFGHMC was on trauma diversion to UCSF as a precaution, however, no trauma patients were diverted during that time. PG&E power was restored to the Campus at 2:25 a.m.

Through this incident, staff is addressing the following areas for improvement:

- Emergency lights: some older emergency lights were not functioning, which was particularly problematic in the OR. Emergency lights need to be installed in acute psychiatry.
- Not all nurses during the night shift knew where flashlights were stored
- Although computers in the data center had backup generators, there were no emergency overhead or hallway lights, forcing staff to use flashlights to check on servers
- The air conditioning system in the data center was not strong enough, causing temperatures to rise at dangerous levels
- Red brick buildings that house clinics and offices such as Information Systems and Finance do not have backup generators, which would be problematic if a power failure occurred during business hours
- Physical work areas for hospital operators and the Help Desk were kept electrified through backup generators; however, their ability to use the network to directly page staff was disabled, forcing them to use manual paging systems

Staff is looking into rectifying these problems and also talking with PG&E about the delay in restoring commercial power to the Campus.

Helipad Feasibility Study Update

Work on the Medical Helipad Feasibility Study has continued swiftly and steadily since its inception on Sept. 20th. Major activities that occurred in the past month are as follows:

On October 10, staff from the Trauma Program and Gerson/Overstreet, the architectural firm contracted for the study, answered questions of neighborhood representatives at the SFGH Rebuild Community Advisory Meeting at Community Health Network headquarters. People raised

concerns around the timing and location of construction for a helipad. It was explained that the study is in its initial phases, and addressing questions around noise and safety, flights needed, and the feasibility of having a helipad on Campus are part of the study. Chris Wachsmuth, Associate Administrator for Emergency and Clinical Support, added that the impetus for this study came from vulnerabilities identified in the August 2001 San Francisco Trauma Systems Plan. Since the helipad feasibility study is perceived by the public as part of the SFGH rebuild process and shares similar initial project timelines, staff on both projects are working closely in implementing a community outreach plan. The next Community Advisory Committee meeting is scheduled for November 21.

On October 17, a strategy session was held to discuss the study's objectives and the best ways to communicate its results. Participants included members of the Rebuild Steering Committee, the EMS Agency, DPH Policy Planning, the UCSF Dean's Office, Gerson/Overstreet consultants, and SFGH staff from Emergency Response and the Trauma Program. The meeting helped to clarify terminology, objectives, commonalities and differences between the study and the SFGH Institutional Master Planning process, and also identified potential pitfalls, community sensitivities, and desirable program approaches.

Other Activities:

SFGHMC Tour to Discuss Impact on State Nursing Ratios

Anne Chang, Executive Assistant/Operations Manager, Rita Smith, Nursing Director for Critical Care and Sharon McCole-Wicher, Nursing Director for Psychiatric Services, provided a tour of SFGHMC to orient Mike Robson, one of the City's contracted lobbyists for State issues, accompanied by Colleen Johnson from DPH Planning and Policy, and Alicia Bert from the Mayor's Office. The topic discussed was the potential impact of State regulations being promulgated that mandates minimum nurse-to-patient staffing ratios for acute care hospitals that take effect in January 2004. Proposed regulations include a 1:6 ratio in medical-surgical units, 1:4 in general ER (excluding triage nurses), and 1:6 for inpatient psychiatry that does not include other behavioral health professionals (e.g. mental health counselors, psychologists, social workers). Meeting these ratios would require additional nursing FTE's in the ED, acute psychiatry, and critical care.

Carlos Villalva updated the Committee on the SFGH Rebuild/Institutional Master Plan process and briefly described the main rebuild scenarios.

Commissioners' Comments

- Commissioner Monfredini asked how long the hospital could operate on back-up generators. Mr. Kanaley replied that the law requires 72 hours, but SFGH has approximately 10 days of back-up power. Ms. O'Connell added that after a thorough analysis of the power outage Mr. Kanaley would be preparing an action plan for what needs to be done. Commissioner Monfredini said that the hospital should have a high-level contact at PG&E, given that it is the area's trauma center. She thanked all the staff for their performance during the emergency. With regard to the helipad feasibility study, Commissioner Monfredini asked what the initial reaction to the plan has been. Ms. Wachsmuth said that the neighbors closest to the hospital have been the most vocal in expressing concerns. Concerns have also been raised about the temporary landing site in Bayview Hunters Point, particularly about the health hazards of dust. With regard to the rebuild process, Commissioner Monfredini asked if serious discussions have been held with UC. The regents will not event take up the issue until December 2003, which is a month after the SFGH bond election. She finds it odd that the planning committee continues evaluating co-location scenarios that do not have any potential of being successful. Mr. Villalva replied that it has been valuable to go through

the planning process, which will enable them to answer questions about possible co-location with UC. Ms. O'Connell said she, Dr. Katz and Tony Wagner met with State Senator Jackie Speier to discuss possible modification to the deadlines. She added that co-location offers a lot of benefits to both sides. Dr. Luce said that the planning process has allowed the medical staff the opportunity to do its due diligence and determine their objectives. Commissioner Monfredini asked that, when the scenarios are presented to the Health Commission, they each include an assessment of the likelihood that the scenario could be successfully implemented.

- Commissioner Parker echoed the sentiment that the hospital should have a priority status with PG&E. He asked if funds were available to do the needed improvements. Mr. Kanaley responded that SFGH did get an allocation to update the central plant and the hospital should have decent generators in a year. Commissioner Parker asked if the temporary Bayview Hunters Point site would possibly be made permanent. Ms. Wachsmuth said that it will definitely be temporary for medical air access, but she is not sure about police usage. Commissioner Parker said that UC and SFGH need each other to survive. He would like to see that mutual need be the core of the discussions. Dr. Navarro said that the medical leadership held a retreat to examine from their perspective SFGH's most critical needs and use that information to evaluate the optimum location. Dr. Navarro said there is a lot of desire to move on the part of medical staff, and there are many issues around research space. There is even the desire to move to Mission Bay without UCSF. Dr. King said that this recommendation was presented to the Chancellor's Office and the Dean's Office, who now have a better understanding of SFGH's importance.

4) PATIENT CARE REPORT

The Patient Care Report (Attachment A) was distributed to the Joint Conference Committee members at the meeting. Ms. O'Connell gave a verbal update on the RN wage negotiation.

Commissioners' Comments

- Commissioner Monfredini asked if the increased RN wages would still fall behind Kaiser's wages. Ms. O'Connell replied that SFGH is behind Kaiser in wages but not benefits.

5) SFGH ANNUAL REPORT

Gene O'Connell, gave highlights of the 2001-2001 SFGH Annual Report. She gave a demographic overview of the patients who utilize SFGH. She highlighted some of the hospital's substance abuse programs, including the Opiate Treatment Outpatient Program, the Ozanam Center and the Stonewall Project. One of the hospital's focuses over the next year will be preparing for the American College of Surgeons trauma center site visit, which will take place in 2003. She also highlighted SFGH's Zero Tolerance for Violence in the Workplace effort. One of the budget priorities for next year will be funding for computerized provider order entry, which is key to the effort to reduce medication errors.

The FY 2002-03 Strategic Goals are:

- Develop the Facility Master Plan for the Rebuild of SFGH
- Complete Level 1 Trauma designation approval process from the American College of Surgeons
- Complete the helipad feasibility study and plan for air medical access

- Complete program development and open the Avon Foundation Comprehensive Breast Center
- Maximize revenue through improved documentation and charge capture
- Implement information systems that support organizational priorities and implement information systems projects
- Implement changes to place mental health patient at the appropriate level of care within Psychiatric Emergency Services, Acute Psychiatry, MRHR and community treatment facilities
- SFGH will continue to maintain compliance with JCAHO and State licensing standards
- SFGH will work towards decreasing turnover of staff and vacancies

6) PUBLIC COMMENT

None.

7) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

None.

B) Vote on Whether to Hold a Closed Session

Action Taken: The Committee voted to hold a closed session.

The Committee went into closed session at 5:00 p.m. Present in closed session were the same people as in open session with the exception of Anson Moon, Carlos Villalva, Yuhum Digdigan and Maureen O'Neil.

C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

APPROVAL OF CLOSED SESSION MINUTES OF OCTOBER 8, 2002

Action Taken: The Committee approved the closed session minutes of October 8, 2002.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

CONSIDERATION OF CREDENTIALING MATTERS

J. Renee Navarro, M.D., Chief of Staff

Action Taken: The Committee approved the Credentials Report.

MEDICAL STAFF REPORT

J. Renee Navarro, M.D., Chief of Staff

D) **Reconvene in Open Session**

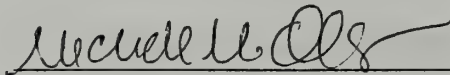
The Committee reconvened in open session at 5:22 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in closed session.

8) **ADJOURNMENT**

The meeting was adjourned at 5:23 p.m.



Michele M. Olson

Executive Secretary to the Health Commission

Attachment (1)

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 11/6/02
Sue Currin, RN, MS, Chief Nursing Office

1. RN WAGE NEGOTIATIONS

Updated verbal report will be given at the meeting.

2. TBI PROGRAM

The program will begin as a pilot on 4B on November 4. After the admission of 10 patients a reevaluation of care per the interdisciplinary team will occur. This includes Rehab (PT,OT,ST), Social Services, Utilization Review, Nutrition, Nursing, Neuropsychology and Neurosurgery Services. Use of an interdisciplinary protocol which has been developed by the team will be used. Weekly IDT meetings will be held to assess and plan care as well as daily rounds.

3. CATH LAB UPDATE

The Cath Lab closed for renovation on October 21. Catheterization procedures are being done in IR on Tuesdays and Thursdays. TEEs are being done on 4C with the assistance of the 4C nursing staff. There have been 2 pacemaker procedures done in the OR. The first procedure caused some concern as the patient required general anesthesia, but with cooperation from all parties, the procedure took place. The Cath Lab Project is scheduled to be completed in August 2003.

4. EDIS PROJECT EXECUTIVE SUMMARY/OVERVIEW

San Francisco General Hospital Medical Center Emergency Department (SFGHMC ED) is a Level 1 Trauma Center with an annual patient census of approximately 60,000.

SFGHMC ED is committed to improving our care and services and feels a sound strategy to achieve this is through the implementation of a comprehensive, integrated emergency department information system (EDIS).

In June 2001, a multidisciplinary team comprised of 12 people including representatives from the emergency department and affiliated departments began meeting regularly with the goal of developing an Emergency Department Information System Request for Proposal. This goal was met on September 1, 2001. The EDIS RFP was sent out to 12 vendors and we received 9 proposals.

An EDIS Selection Committee with representatives from nursing, medicine, and information services was formed. The committee carefully reviewed the 9 proposals, facilitated 4 vendor

demos, and conducted site visits to emergency departments in Ohio and Chicago. By mid-July, 2002, A4 Health Systems HealthMatics ED was selected as our EDIS vendor and the process of beginning contract negotiations commenced.

Project Objectives

The EDIS Project will meet the following objectives:

- Provide a seamless, comprehensive patient documentation tool that allows us to completely document patient visits from initial presentation to follow-up care.
- Provide a system which includes Patient Tracking, Triage, Physician and Nurse Documentation, Prescriptions, Discharge Instructions, Reporting Tools, Facility Charging and Pro-fee coding.
- Provide a system that includes templates or charting pathways that will prompt medical and nursing personnel to provide complete documentation.
- Provide a system that can interface to current CHN/SFGHMC systems on a complex network.
- Provide a qualified implementation team and formal acceptance testing approach that will yield a successful and timely implementation.
- Provide a mechanism to quickly and completely identify the status of a patient visit.
- Provide a system to quickly and completely order tests and obtain test results.
- Provide a robust database that will facilitate clinical research and quality improvement programs.

5. OR GE/ORMIS SYSTEM

The new Periop computer system from General Electric/Operating Room Management Information Systems (GE/ORMIS) is well underway. Information from all of the Peri-operative areas is being compiled and formulated into a form that will flow from one care event to another. Information tables are near completion, file uploads of surgery related items, surgical procedures and medical staff are due to be uploaded within the week. Bill Chun RN (OR) and Jan Allison RN (IS) and other members of the ORMIS Project Team have attended 4 scheduled blocks of classes related to this building project. The 5th and final class is scheduled for the week of November 12th. Assessments have been made to enhance electronic patient documentation in the Surgicenter and PACU.

A comprehensive training program is being developed with training for Surgicenter, OR, PACU and SPD super users and staff to occur in December and January. On December 15th we plan to start "double scheduling" cases (scheduling future cases in both our current Surgiserver system and the new ORMIS system).

Planned implementation date of the new system for Surgicenter, the OR and SPD is in February of 2003. PACU is scheduled to "go live" with ORMIS in March, 2003, At this point in time, we

appear to be on schedule for our "go live" date(s). We realize we still have a lot of hard work ahead of us, But we are looking forward to it with great relish and anticipation.

6. RETENTION AND RECRUITMENT

Current overall Nursing vacancy rate: 14%, RN vacancy rate: 10%, LVN vacancy rate: 10%. (Overall vacancy rate is higher due to CNS and NP openings.) ED RN vacancies are currently at 2.9; Emergency Department Training Program started 11/6 with 4 hires; another EDTP is planned for early 2003. Critical Care is planning a training program for January 2003. The Birth Center will also be offering an individualized training program to fill vacant RN positions.

Unfortunately, San Francisco and San Mateo counties did not receive a grant through the Nursing Workforce Initiative. This grant was targeted at providing funds for incumbent employees to move up the nursing career ladder. We continue to work with the SF PIC to obtain funding. The PIC is considering submitting a similar proposal to the federal H1B grant program. We will also be working with the PIC on a needs survey for remedial courses which will allow entry level workers to advance. This effort is being funded by the Haas Foundation.

Gene O'Connell and Leslie Holpit recently met with Dr Fernandez-Pena and Brenda Storey of the San Francisco Welcome Back Center. The Center works with foreign-trained healthcare professionals, assisting them in obtaining degrees or licenses in order to work in the US. Both SFGH and Welcome Back are very interested in collaborating with one another to enhance the training and job placement opportunities. Welcome Back provides a LVN Refresher Program and hopes to begin a RN Refresher program. We are eager to partner with Welcome Back on these initiatives.

San Francisco General Hospital

Diversion Report

October 2002

1. EXECUTIVE SUMMARY

The Emergency Department [ED] recorded 34 episodes of diversion for 142 hours representing a rate of 19% in October 2002. This is a 12.7% decrease in diversion since September 2002.

The 34 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from Previous Month
Total Diversion	34	142	19	12.7
Trauma Override	3	5.5	.8	2.2%

The ED was impacted by capacity and high patient acuity during the episodes of Total Diversion. During this time, 197 patients were pending admission to inpatient beds [ICU-19, 4B/StepDown-96, MedSurg-82]. In October 2001, the ED was on diversion 30.6% of the month. Trauma Override was invoked 1.6% of the month in October 2001.

Total Diversion was recorded for 34 episodes, a total of 142 hours or a 19% rate for October 2002, and a 12.7% decrease in Total Diversion since September 2002. While on Total Diversion the ED held 197 patients in October 2002. While on Total Diversion in October 2001, the ED held 238 patients awaiting inpatient beds.

Trauma Override was recorded for 3 episodes, a total of 5.5 hours or a .8% rate for October 2002. This is a 2.2% decrease in Trauma Override since September 2002. While on Trauma Override the ED held 7 patients in October 2002. While on Trauma Override in October 2001, the ED held 28 patients awaiting inpatient beds.

2. DEFINITIONS:

SFGH Internal Trauma Activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSS Definitions:

Total Diversion: When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override: When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

Prepared by: Sharon Kennedy R.N.
Base Hospital Coordinator
Erthemese Elias
Base Hospital Assistant

3. TRAUMA DIVERSION SUMMARY

The Emergency Department recorded 3 episodes of Trauma Override for 5.5 hours, a percentage of .8% for the month of October.

Date	Length	Summary of Event
10/05/02	2125-2230 (1h 5m)	911-1 912-3 910-0
10/15/02	2100-0030 (3h 30m)	911-2 912-0 910-1
10/25/02	1815-1910 (55m)	911-0 912-0 910-0

4. TOTAL DIVERSION SUMMARY

In October, the Emergency Department recorded 33 episodes of Total Diversion for 139 hours, a percentage of 18.7% for the month.

Date	Length	Summary of Event
10/02/02	1645-1950 (2h 53m)	36 patients in the ED Admits: 1-ICU; 2-4B; 3-Floor ED waiting room: 6 urgent patients

10/03/02	1257-1745 (4h 47m)	36 patients in the ED Admits: 3-4B; 1-Floor ED waiting room: 13 urgent patients
10/03/02	2050-0230 (5h 40m)	36 patients in the ED Admits: 2-4B; 8-Floor ED waiting room: 5 urgent patients
10/04/02	1340-2400 (10h 20m)	44 patients in the ED Admits: 5-4B; 3-Floor ED waiting room: 12 urgent patients
10/05/02	0430-0540 (1h 10m)	34 patients in the ED Admits: 1-ICU; 5-4B; 1-Floor ED waiting room: 3 urgent patients
10/05/02	1725-0245 (9h 20m)	36 patients in the ED Admits: 1-ICU; 3-4B ED waiting room: 10 urgent patients
10/07/02	0225-0425 (2h)	32 patients in the ED Admits: 1-4B; 2-Floor ED waiting room: 4 urgent patients
10/07/02	1340-1630 (2h 50m)	46 patients in the ED Admits: 1-4B; 2-Floor ED waiting room: 3 urgent patients
10/07/02	1645-1810 (1h 25m)	32 patients in the ED Admits: 2-ICU; 5-4B ED waiting room: 10 urgent patients
10/08/02	1620-1930 (3h 10m)	32 patients in the ED Admits: 2-ICU; 5-4B ED waiting room: 10 urgent patients
10/09/02	1410-2110 (7h)	38 patients in the ED Admits: 1-4B; 1-Floor ED waiting room: 9 urgent patients
10/13/02	1440-2020 (5h 40m)	37 patients in the ED Admits: 1-4B ED waiting room: 2 urgent patients
10/14/02	1515-2238 (7h 23m)	38 patients in the ED Admits: 2-Floor ED waiting room: 14 urgent patients
10/15/02	1750-0440 (10h 50m)	36 patients in the ED Admits: 2-4B; 3-Floor ED waiting room: 7 urgent patients
10/17/02	1312-1455 (1h 43m)	35 patients in the ED Admits: 1-ICU; 4-4B; 2-Floor ED waiting room: 7 urgent patients
10/17/02	1830-2100 (2h 30m)	35 patients in the ED Admits: 2-4B; 5-Floor ED waiting room: 5 urgent patients
10/18/02	1700-2350 (6h 50m)	36 patients in the ED Admits: 2-4B; 7-Floor ED waiting room: 6 urgent patients
10/20/02	2050-2150 (1h)	37 patients in the ED Admits: 2-4B ED waiting room: 3 urgent patients
10/21/02	1545-1700 (1h 15m)	36 patients in the ED Admits: 2-ICU; 1-4B; 2-Floor ED waiting room: 4 urgent patients
10/21/02	2000-2115 (1h 15m)	34 patients in the ED Admits: 2-ICU; 1-Floor ED waiting room: 4 urgent patients
10/21/02	2340-0328 (3h 48m)	37 patients in the ED Admits: 2-Floor ED waiting room: 8 urgent patients
10/24/02	1404-1620 (2h 16m)	33 patients in the ED Admits: 5-4B; 3-Floor ED waiting room: 7 urgent patients
10/24/02	2317-0545	41 patients in the ED Admits: 1-ICU; 2-4B; 4-Floor

	(6h 28m)	ED waiting room: 10 urgent patients
10/25/02	1645-2135 (4h 45m)	37 patients in the ED Admits: 5-4B ED waiting room: 5 urgent patients
10/26/02	0351-0558 (2h 7m)	31 patients in the ED Admits: 1-ICU; 4-4B; 2-Floor ED waiting room: 2 urgent patients
10/26/02	1840-2342 (5h 2m)	37 patients in the ED Admits: 5-Floor ED waiting room: 4 urgent patients
10/27/02	0955-1205 (2h 10m)	40 patients in the ED Admits: 8-4B; 1-Floor ED waiting room: 12 urgent patients
10/27/02	1950-2150 (2h)	36 patients in the ED Admits: 4-4B; 5-Floor ED waiting room: 5 urgent patients
10/28/02	1230-1605 (3h 35m)	37 patients in the ED Admits: 6-4B; 3-Floor ED waiting room: 10 urgent patients
10/29/02	1257-1650 (3h 53m)	35 patients in the ED Admits: 1-ICU; 4-4B; 3-Floor ED waiting room: 7 urgent patients
10/30/02	1157-1432 (2h 40m)	29 patients in the ED Admits: 1-ICU; 6-4B; 2-Floor ED waiting room: 6 urgent patients
10/30/02	1850-2030 (1h 40m)	43 patients in the ED Admits: 2-ICU; 2-4B; 1-Floor ED waiting room: 3 urgent patients
10/31/02	1430-2359 (9h 29m)	42 patients in the ED Admits: 1-ICU; 1-Floor ED waiting room: 10 urgent patients

City and County of San Francisco
HEALTH COMMISSION
Department of Public Health
101 Grove Street, Room #311
San Francisco, CA 94102

(Address Correction Requested)

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Edward A. Chow, M.D.
President

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Vice President

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AGENDA

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, December 10, 2002
4:30 p.m. - 6:00 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

***PLEASE NOTE CHANGE IN TIME**

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Commissioner Lee Ann Monfredini, Chair
Commissioner Harrison Parker, Sr. DDS

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- 1) **CALL TO ORDER**
- 2) **PROPOSED ACTION:** **APPROVAL OF MINUTES OF NOVEMBER 12, 2002**
**Minutes of November 12, 2002*
- 3) **FOR DISCUSSION:** **HOSPITAL HEALTHCARE UPDATE**
(Gene Marie O'Connell, Executive Administrator, SFGHMC)
**Report*
- 4) **FOR DISCUSSION:** **PATIENT CARE REPORT**
(Sue Currin, R.N., Chief Nursing Officer)
**Report*

5) **PUBLIC COMMENT****

6) **CLOSED SESSION**

- A) Public Comments on All Matters Pertaining to the Closed Session
- B) Vote on Whether to Hold a Closed Session
- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

ACTION ITEM: **APPROVAL OF CLOSED SESSION**
MINUTES OF NOVEMBER 12, 2002

FOR DISCUSSION: **CONSIDERATION OF MEDICAL AUDIT,**
QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

FOR ACTION: **CONSIDERATION OF CREDENTIALING MATTERS**
J. Renee Navarro, M.D., Chief of Staff

FOR DISCUSSION **MEDICAL STAFF REPORT**
AND POSSIBLE J. Renee Navarro, M.D., Chief of Staff
ACTION:

D) Reconvene in Open Session

- 1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
- 2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

7) **ADJOURNMENT**

* Explanatory documents are available at the Joint Conference Committee, 101 Grove Street, Room #311.

** Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that are within the subject matter jurisdiction of the Joint Conference Committee. Additionally, public comments will be taken for each agenda item.

Disability Access

Conference Room 2A6 is wheelchair accessible. It is located on the second floor of the Main Building. Public parking is available on 23rd Street, from where you enter the Main Building.

Take an elevator to the second floor, and look for Room 2A6. Parking is also available at 22nd Street and Potrero Avenue.

American sign language interpreters and readers are available during the meeting upon request. Minutes of the meeting/event are available in alternative formats also upon request. Please call the Patient Referral/Assistance Department at 206-5166 at least 5 business days in advance of need. Late requests will be honored if possible.

A sound enhancement system is also available upon request by calling the Plant Services Department at 206-8550 at least 72 hours prior to the meeting/event. Late requests will be honored if possible.

To allow individuals with environmental illness or chemical sensitivity to attend meetings/events, individuals are requested to refrain from wearing perfume or other scented products.

Public Transportation

The hospital is accessible by wheelchair-friendly Muni Lines **#9 San Bruno**, **#9X San Bruno Express**, **#19 Polk** (stops 2 blocks away), **#33 Haight Ashbury**, and **#48 Quintara**. For further information regarding Muni transportation, please call 923-6142, 673-MUNI, and 923-6366 (TDD).

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Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact the Sunshine Ordinance Task Force at: Sunshine Ordinance Task Force, Donna Hall, Administrator, City Hall, Room #244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102-4689; telephone (415) 554-7724; fax (415) 554-5163; and e-mail: **Donna_Hall@ci.sf.ca.us**.

Copies of the Sunshine Ordinance can be obtained from the Clerk of the Sunshine Task Force, (listed above), the San Francisco Public Library, and on the City's web site at:

www.ci.sf.ca.us/bdsupvrs/sunshine/ordinance.htm

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MINUTES

JOINT CONFERENCE COMMITTEE FOR SAN FRANCISCO GENERAL HOSPITAL (SFGH) MEETING

Tuesday, December 10, 2002
4:30 p.m. - 6:00 p.m.
1001 Potrero, Conference Room #2A6
San Francisco, CA 94110

DOCUMENTS DEPT.

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1) CALL TO ORDER

The meeting was called to order by Commissioner Monfredini at 4:32 p.m.

Present: Commissioner Lee Ann Monfredini, Chair
Commissioner Harrison Parker, Sr. DDS

Staff: Rod Auyang, Anne Chang, Sue Currin, Myra Garcia, Mozettia Henley,
Valerie Inouye, John Luce, M.D., Renee Navarro, M.D., Gene O'Connell,
Roland Pickens, Ann Stangby, Hiro Tokubo and Anthony Wagner.

2) APPROVAL OF MINUTES OF NOVEMBER 12, 2002

Action Taken: The Committee approved the minutes of the November 12, 2002 San Francisco General Hospital Joint Conference Committee meeting.

3) HOSPITAL HEALTHCARE UPDATE

Gene Marie O'Connell, Executive Administrator, SFGHMC, presented the Hospital Healthcare Update.

PROGRAM UPDATES

Small Pox Vaccination Survey

Last week, the Federal government issued a mandate to offer pre-event small pox vaccination to a limited number of public health and hospital-based staff who would serve as key responders to an outbreak. The State of California Department of Health Services assures that there is no specific threat promoting this planning. SFDPH anticipates that vaccines would be available within the next four to eight weeks. Any administration of the vaccine would be voluntary.

SFDPH has directed that a select group of staff be surveyed by December 20 for their willingness to be vaccinated for small pox. SFGHMC is taking the approach of surveying all staff in order to obtain comprehensive data on willingness to get vaccinated and participate as a key responder. Along with the survey, staff has been provided information on the risks of adverse outcome and contraindications to the vaccine. In addition, the vaccinia virus replicates at the inoculation site for several weeks, requiring that staff follow careful infection control procedures after vaccination to avoid spread. Some concerns raised by SEIU and other staff include: health risks from the vaccine, preventing the spread of vaccinia to non-vaccinated persons, particularly those with contraindications, loss of income if an employee is unable to work, and needle stick safety.

SFGHMC has been communicating with SEIU and has set up staff meetings to distribute information and answer questions at Carr Auditorium on December 12 and 18 at noon. The EMS Agency is also sponsoring a town hall meeting for San Francisco hospitals on December 16 from 3:30-5:00 p.m. at Carr Auditorium.

Medical Helipad Feasibility Study Update

Work on the Medical Feasibility Study has begun to enter a more public stage, focusing on community outreach. On November 14, Al Williams and David Prowler, community outreach consultants for the SFGH Rebuild and the Medical Helipad, held a training session for SFGH and DPH staff on how to present information to the community and what are some anticipated questions. Individual meetings were held with the following community groups:

- East Mission Neighborhood Group (November 18)
- Potrero Hill Boosters (November 19)
- Mission Community Leaders (November 25)

Comments varied among the groups. Many raised concerns around noise and safety, adamantly opposing the rebuild of the hospital and the helipad at the Potrero site. However, there was also strong support voiced for the mission of the hospital and maintaining its Level 1 trauma center, particularly from Mission Community Leaders, who want the hospital to stay in the Mission District.

SFGH Rebuilt Update

Anthony Wagner presented an update on the SFGH Rebuild (Attachment A).

Commissioners' Comments

- Commissioner Parker asked if SFGH has a "wait and see" approach to smallpox vaccinations. Ms. O'Connell said initially the thought was they would vaccinate when there was an incident. However, now the CDC is mandating that DPH have a plan for administering the vaccination.

Commissioner Parker asked how critical the helipad is to maintaining critical mass in the trauma center. Ms. O'Connell said the helipad is essential to critical mass. With regard to the rebuild, Commissioner Parker said that experts have predicted a major earthquake in the next 25 years and we need to keep this in mind. Also, the longer the delay, the more expensive the project will be.

- Commissioner Monfredini said that San Francisco might not be the only city seeking a legislative delay, giving the budget crisis facing the State and the inability of local governments to raise money for new facilities. She is impressed with the medical staff leadership's plan. She supports waiting another year for a bond issue.

4) PATIENT CARE REPORT

Sue Currin, R.N., Chief Nursing Officer, presented the Patient Care Report (Attachment B). She announced that a two-year contract extension with the SEIU 790 nurses was approved last week, and salaries were brought up to the UC level. The Department will begin negotiations with the Supervising Nurses next week.

She also gave an update on the status of the per diem nursing contracts. Med Staff and Medical Staffing Network have performed well and they will be recommended for renewal. The contracts with C.W. Healthcare and Maxim will be terminated because they have not been able to meet SFGH's nursing staff needs.

Commissioners' Comments

- Commissioner Parker asked for additional information on the two days in November when there were 53 and 54 patients in the ED. Ms. Currin said that this is a higher than normal number, and she will get information for the Commissioners.

5) PUBLIC COMMENT

None.

6) CLOSED SESSION

A) Public Comments on All Matters Pertaining to the Closed Session

None.

B) Vote on Whether to Hold a Closed Session

Action Taken: The Committee voted to hold a closed session.

The Committee went into closed session at 5:12 p.m. Present in closed session were Roland Pickens, John Luce, M.D., Gene O'Connell, Anne Chang, Myra Garcia, Renee Navarro, M.D., Mozettia Henley, Hiro Tokubo and Michele Olson.

- C) Closed Session Pursuant to Evidence Code Sections 1157(a) and (b); 1157.7, Health and Safety Code Section 1461; and California Constitution, Article I, Section 1

APPROVAL OF CLOSED SESSION MINUTES OF NOVEMBER 12, 2002

Action Taken: The Committee approved the November 12, 2002 closed session minutes.

CONSIDERATION OF MEDICAL AUDIT, QUALITY OF CARE, QUALITY ASSURANCE

John Luce, M.D., Medical Director SFGH-QM
Hiroshi Tokubo, CHN Director, QM
Alison Moed, Director of Risk Management

CONSIDERATION OF CREDENTIALING MATTERS

J. Renee Navarro, M.D., Chief of Staff

Action Taken: The Committee approved the December 2002 Credentials Report.

MEDICAL STAFF REPORT

J. Renee Navarro, M.D., Chief of Staff

- D) Reconvene in Open Session

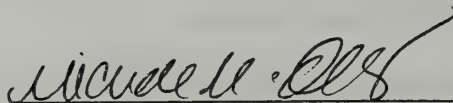
The Committee reconvened in open session at 5:50 p.m.

1. Possible Report on Action Taken in Closed Session (Government Code Section 54957.1(a)2 and San Francisco Administrative Code Section 67.12(b)(2).)
2. Vote to Elect Whether to Disclose Any or All Discussions Held in Closed Session (San Francisco Administrative Code Section 67.12(b)(2).)

Action Taken: The Committee voted not to disclose any discussions held in closed session.

7) **ADJOURNMENT**

The meeting was adjourned at 5:51 p.m.



Michele M. Olson
Executive Secretary to the Health Commission

Attachments (2)

DATE: December 9, 2002

TO: Lee Ann Monfredini, Chair, and
San Francisco General Hospital Medical Center Joint Conference
Committee Members

FROM: Anthony G. Wagner, Executive Administrator
Hospital Systems

RE: San Francisco General Hospital Medical Center Rebuild Update

Commissioner Monfredini and members of the SFGHMC Joint Conference Committee, below please find an update of the most recent activities of the San Francisco General Hospital Medical Center (SFGHMC) Rebuild planning process.

SFGHMC Rebuild Planning Update

Subcommittee Activities

Planning efforts are continuing for the SFGHMC Rebuild. Subcommittees are continuing to work through unresolved issues. We have given the Ambulatory Care subcommittee additional time to address issues raised by the Lewin report; e.g., a "super clinic"; absorbing 40,000 clinic visits from the Hospital into community clinic settings; adding an additional 20,000 new visits to community based clinics, etc. They have organized and held two meetings.

SFGHMC Medical Staff Leadership Proposal

The Medical Staff Leadership of SFGHMC recently held a retreat to discuss options for the rebuilding of SFGHMC. They expressed strong support for relocation of the hospital to Mission Bay, regardless of any decision concerning the location of a new University of California, San Francisco Medical Center (UCSFMC). It was felt that this location would be optimal for the recruitment and retention of faculty because it would provide the best potential for research space (both desk top- and bench) and also would provide the critical mass of faculty to maintain a viable academic community. It was also felt the Mission Bay site would also enable more flexibility in structuring patient care services, especially trauma services. The group recognized that there are major barriers that would have to be surmounted in order to move SFGHMC to Mission Bay; however, it was felt that the potential benefits justify the effort that will be required.

We will include this option among several others as we request various stakeholder groups to rank them. We introduced and tested our first ranking instrument last Thursday with the Combined SFGHMC Rebuild Advisory Committee. We received much helpful

feedback to assist us in refining it. We will discuss the scenarios and ranking criteria at our next bi-weekly steering committee meeting.

DPH/UCSF Collocation Discussions

Discussions between the Department of Public Health (DPH) and UCSFMC regarding collocation continue. The two organizations have decided to retain and jointly fund the services of a consulting firm to assist us in deciding whether to move forward in developing a collocation plan.

Outreach Activities

Our external outreach efforts are ongoing. Both the Rebuild and the Helipad Feasibility Study are discussed at all community outreach meetings. The subjects are discussed in separate presentations, but both are discussed in order that we prospectively share all major planning efforts with our communities. We recently held a training session for those staff that would be potential community speakers.

We have already presented to the East Mission Neighborhood Association, and the Potrero Boosters. Members of both of these groups expressed concerns about placing a helipad on the SFGHMC campus. Many of them also expressed support for relocating the campus to the Mission Bay site. We have also presented to SPUR.

Following up with a suggestion from Commissioner Sanchez, we joined him in a meeting with leaders of several Mission Neighborhood Community organizations to receive their input, concerns and guidance regarding the rebuild. Much concern was raised about the possible relocation of SFGHMC from the current Potrero Site. Many of the concerns focused on the possible loss of easy access to services provided by SFGHMC. Concerns were also raised about the potential economic loss to neighborhood businesses. A much larger meeting is being planned in the near future from names that were recommended by those attending the meeting. Another presentation is scheduled with SPUR and one with NICOS in January.

Our internal outreach also continues. Regular updates will be presented to both the SFGHMC Administrative and Medical Staff Executives Committees.

Our next update to the full Commission has been rescheduled from December 3rd to January 21st. We will keep the Commission apprised of our activities through this and the SFGHMC Joint Conference Committees and through updates to the full Health Commission.

check master calendar -

PATIENT CARE SERVICES REPORT

Submitted to the JCC, 12/4/02
Sue Currin, RN, MS, Chief Nursing Office
San Francisco General Hospital

DIVERSION REPORT, NOVEMBER 2002

1. Executive Summary

The Emergency Department [ED] recorded 36 episodes of diversion for 169 hours representing a rate of 23.5% in November 2002. This is a 4.5% increase in diversion since October 2002.

The 36 episodes of diversion are categorized as follows:

Diversion Type	# Episodes	Hours	Rate	% Change from Previous Month
Total Diversion	36	169	23.5	4.5%
Trauma Override	3	13.25	1.8	1%

The ED was impacted by capacity and high patient acuity during the episodes of Total Diversion and Trauma Override. During this time, 200 patients were pending admission to inpatient beds [ICU-16, 4B/StepDown-68, MedSurg-116]. In November 2001, the ED was on diversion 27% of the month. Trauma Override was not invoked during the month in November 2001.

Total Diversion was recorded for 36 episodes, a total of 169 hours or a 23.5% rate for November 2002, and a 4.5% increase in Total Diversion since October 2002. While on Total Diversion the ED held 200 patients in November 2002. While on Total Diversion in November 2001, the ED held 173 patients awaiting inpatient beds.

Trauma Override was recorded for 3 episodes, a total of 13.25 hours or a 1.8% rate for November 2002. This is a 1% increase in Trauma Override since October 2002. While on Trauma Override the ED held 14 patients in November 2002. There were zero episodes of Trauma Override in November 2001.

2. Definitions:

SFGH Internal Trauma Activation:

The trauma override summary explains trauma patients in the emergency department as 911, 912, 910 and 999. A 911 is a critical trauma patient. A 912 is a potentially critical trauma patient. A 910 is a critical pediatric patient. Finally, a 999 is a multiple casualty incident involving 3 or more critical trauma patient.

EMSS Definitions:

Total Diversion: When a receiving hospital Emergency Department determines, through pre-established criteria, that the Emergency Department is unable to provide care to additional ambulance patients AND communicates this change in status to the SFFD Comm center.

Trauma Override: When SFGH continues Total diversion during a period of Total diversion suspension. During Trauma Override, SFGH shall continue the diversion of medical patients, {or all non-trauma and other Special care patients if on total diversion} while continuing to accept patients meeting trauma center destination and specialty care criteria.

The following three conditions must be met:

1. The critical care bed capacity at SFGH is two or less beds.
2. All SFGH internal diversion strategies have been exhausted
3. There is at least one trauma patient in the process of evaluation/ treatment in the SFGH trauma care system.

*Prepared by: Sharon Kennedy R.N.
Base Hospital Coordinator
Erthemese Elias
Base Hospital Assistant*

3. Trauma Override Summary

The Emergency Department recorded **3** episodes of Trauma Override for **13.25** hours, a percentage of **1.8%** for the month of November.

Date	Length	Summary of Event
11/14/02	1540-2125 (5h 45m)	911-1 912-4 910-0
11/19/02	1815-2055 (2h 40m)	911-1 912-1 910-0
11/27/02	1600-2050 (4h 50m)	911-2 912-1 910-0

4. Total Diversion Summary

In November, the Emergency Department recorded **36** episodes of Total Diversion for **169** hours, a percentage of **23.5%** for the month.

Date	Length	Summary of Event
11/01/02	0000-0732 (7h 32m)	36 patients in the ED Admits: 1-4B; 6-Floor ED waiting room: 2 urgent patients
11/03/02	0302-0517 (2h 15m)	31 patients in the ED Admits: 1-4B; 1-Floor ED waiting room: 3 urgent patients

11/03/02	1630-2000 (3h 30m)	35 patients in the ED Admits: 1-ICU; 2-Floor ED waiting room: 4 urgent patients
11/04/02	1325-1650 (3h 25m)	34 patients in the ED Admits: 1-4B ED waiting room: 6 urgent patients
11/04/02	1815-0215 (8h)	32 patients in the ED Admits: 1-4B; 7-Floor ED waiting room: 9 urgent patients
11/05/02	1420-1640 (2h 20m)	36 patients in the ED Admits: 3-4B; 1-Floor ED waiting room: 10 urgent patients
11/06/02	1411-1630 (2h 19m)	35 patients in the ED Admits: 1-ICU; 2-4B; 2-Floor ED waiting room: 7 urgent patients
11/07/02	1245-0005 (11h 20m)	37 patients in the ED Admits: 1-4B; 1-Floor ED waiting room: 9 urgent patients
11/08/02	0055-0205 (1h 10m)	0 patients in the ED (<i>Blackout; Trauma Diversion</i>) Admits: 0 ED waiting room: 0 urgent patients
11/08/02	0900-1110 (2h 10m)	34 patients in the ED Admits: 1-ICU; 7-Floor ED waiting room: 6 urgent patients
11/10/02	1210-2110 (9h)	39 patients in the ED Admits: 1-Floor ED waiting room: 3 urgent patients
11/11/02	1100-1300 (2h)	53 patients in the ED Admits: 1-ICU; 4-4B; 1-Floor ED waiting room: 10 urgent patients
11/11/02	1425-0325 (13h)	54 patients in the ED Admits: 7-4B; 5-Floor ED waiting room: 10 urgent patients
11/12/02	1340-1625 (2h 45m)	32 patients in the ED Admits: 2-ICU; 3-4B; 2-Floor ED waiting room: 4 urgent patients
11/12/02	1600-1705 (1h 5m)	37 patients in the ED Admits: 2-4B; 3-Floor ED waiting room: 0 urgent patients (confirmed by R.Hardie)
11/12/02	2200-0230 (4h 30m)	36 patients in the ED Admits: 5-Floor ED waiting room: 7 urgent patients
11/14/02	1240-1536 (2h 56m)	35 patients in the ED Admits: 1-ICU; 3-4B; 2-Floor ED waiting room: 8 urgent patients
11/16/02	1700-1905 (2h 5m)	32 patients in the ED Admits: 2-4B; 2-Floor ED waiting room: 6 urgent patients
11/16/02	2045-0003 (3h 18m)	35 patients in the ED Admits: 2-4B ED waiting room: 5 urgent patients
11/17/02	1145-1730 (5h 45m)	35 patients in the ED Admits: 1-ICU; 2-4B; 1-Floor ED waiting room: 4 urgent patients
11/17/02	2228-2328 (1h)	37 patients in the ED Admits: 2-4B; 3-Floor ED waiting room: 4 urgent patients
11/18/02	1417-2220 (6h 3m)	39 patients in the ED Admits: 1-4B; 3-Floor ED waiting room: 6 urgent patients
11/19/02	1357-1810 (4h 13m)	46 patients in the ED Admits: 1-ICU; 2-4B; 5-Floor ED waiting room: 15 urgent patients
11/19/02	2050-2340	37 patients in the ED Admits: 1-ICU; 3-4B; 3-Floor

	(2h 50m)	ED waiting room: 17 urgent patients
11/20/02	1127-1700 (4h 33m)	37 patients in the ED Admits: 1-ICU; 6-4B; 8-Floor ED waiting room: 6 urgent patients
11/20/02	2015-0315 (7h)	37 patients in the ED Admits: 4-4B; 6-Floor ED waiting room: 9 urgent patients
11/21/02	1645-0245 (8h)	36 patients in the ED Admits: 1-ICU; 9-Floor ED waiting room: 11 urgent patients
11/23/02	0220-0452 (2h 32m)	35 patients in the ED Admits: 1-ICU; 1-4B; 8-Floor ED waiting room: 8 urgent patients
11/23/02	1905-0307 (8h 2m)	36 patients in the ED Admits: 2-4B; 3-Floor ED waiting room: 10 urgent patients
11/24/02	1412-1605 (1h 53m)	36 patients in the ED Admits: 1-Floor ED waiting room: 3 urgent patients
11/24/02	2020-2355 (3h 35m)	36 patients in the ED Admits: 5-4B; 5-Floor ED waiting room: 10 urgent patients
11/25/02	1221-1845 (6h 24m)	34 patients in the ED Admits: 1-ICU; 1-4B; 5-Floor ED waiting room: 6 urgent patients
11/26/02	1038-2005 (9h 27m)	35 patients in the ED Admits: 2-4B; 2-Floor ED waiting room: 8 urgent patients
11/26/02	2356-0422 (4h 26m)	31 patients in the ED Admits: 2-4B; 3-Floor ED waiting room: 16 urgent patients
11/27/02	1245-1558 (3h 13m)	32 patients in the ED Admits: 2-ICU; 2-4B; 2-Floor ED waiting room: 10 urgent patients
11/30/02	0017-0545 (5h 28m)	38 patients in the ED Admits: 1-Floor ED waiting room: 4 urgent patients

